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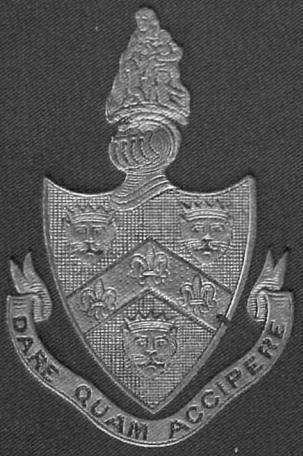

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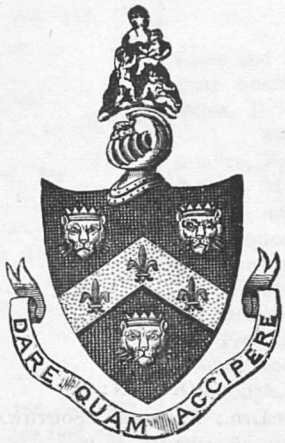

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GUY'S HOSPITAL GAZETTE.

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Calendar of Coming Events and Ensuing Take-in Weeks.

January.

Sat. 8. 1st XV. v. Rosslyn Park (Away).
2nd XV. v. Lennox "A" (Home).
1st XI. v. Eversleigh (Away).

Mon. 10. Clinical Lecture by Sir Cooper Perry (Dermatology), 1.15 p.m.
Physiological Society meeting, 4 p.m.

Tues. 11. Final Conjoint Examination begins.

Wed. 12. 1st XV. v. Chatham R.N.R. United (Home).
1st XI. v. Old Felstedians (Home).

Thur. 13. Messrs. Dunn and Rowlands' Take-in (Messrs. Lucey and Johnston).

Sat. 15. 1st XV. v. Blackheath (Home).
2nd XV. v. Æsculapians (Away).
1st XI. v. Old Westminsters (Home).
2nd XI. v. Reigate Priory "A" (Away).
Debating Society Meeting, 8 p.m.

Mon. 17. Clinical Lecture by Mr. Rowlands (Orthopædics), 1.15 p.m.

Wed. 19. Physical Society: Clinical meeting (President, C. M. Plumptre), 8 p.m.

Thur. 20. Sir Alfred Fripp and Mr. Turner's Take-in (Messrs. Lee and Duvivier).

Passim.

THE present issue of the GAZETTE opens the 24th volume. An index and title-page to the past volume are being prepared. Subscribers who desire their numbers bound should send them to the Librarian with 1s. 6d. The bindings are in two shades of blue, with the hospital arms in gold.

WE should here like to urge all Guy's men or nurses, past and present, to send to the GAZETTE contributions of all kinds on matters of clinical, scientific or general interest. The GAZETTE is the only link between many past students and nurses and their hospital, and its interest and value are obviously much increased if as large a number as possible not only read it, but contribute to it. Poets are scarce, and artists; but many men will find themselves writing good prose unconsciously, as M. Jourdain talked it, if they only try. And, in professional subjects, matter is so much more important than manner that no one, who has something worth saying, need hesitate to say it for lack of style, as the medical journals amply testify.

WE have yet another pleasant New Year's reminder for old Guy's men in that it is once again the year for our Biennial Dinner, at which so many look forward to meeting old friends of student days and others, even though only for a few hours. The success of the 1908 dinner was so striking that it scarcely seems likely those responsible for the arrangements will make any material alterations this year.

In 1908 there were 331 present at the dinner, a record by 42, but one which we hope may be beaten in 1910. Whether this success was mainly due to the absence of speeches, and consequently increased time afforded for talking to friends, or to the arrangements of the diners at small tables, or to the fact that the price of the dinner ticket was fixed at 10s. 6d., exclusive of wine, we cannot say; probably it was the happy combination of all three. Naturally enough, these innovations did not find favour with all, although there was little doubt that a large majority of those present approved—and the minority, we hope and believe, enjoyed—their evening little, if any, the less than on former occasions. If any old Guy's men have suggestions to make for this year's festival, we shall be very glad to receive them, and to pass them on to the proper quarter for consideration. For many years past the dinner has been held during the first week in July, the exception being in 1896, when it was deferred until October on account of the dinner at the Imperial Institute in June of that year held on behalf of the Sustentation Fund. It is probable, we suppose, that the July date will be adhered to this year.

CHRISTMAS—and a very successful Christmas, too—is safely over! We breathe again. The various festivities are fully set forth elsewhere in this issue, so we need not do more here than mention some facts of general interest. In the first place, the Niggers, both as regards appearance and performance, were exceptionally good, and Mr. Martyn Lobb, who had coached both band and chorus, is to be warmly congratulated on their success. Then Mr. Wingent, as usual, worked like a nigger at drawings for programmes and posters, and he responded nobly to the various demands on his skill. Among the other artists whose posters lent colour to the Colonnade were Mr. Constant and Mr. Vicary. Everyone else, including the patients, who worked to make the hospital Christmas the success it was, we thank and congratulate here, though their efforts have probably been generously rewarded already by the happiness the work brought them.

WE hear that a number of collecting cards for the Out-Patients' Tea have not yet been returned to the Secretary; so we would ask all who have them to return them, with the amounts collected, as soon as possible to Mr. Mullins, in order that the accounts of the Tea may be made out and published here.

A SOMEWHAT virulent letter, setting forth the grievances of a resident in the College, appeared in our last issue under the heading "College Amenities." Whether these grievances should have been aired in our columns or taken direct to the authorities concerned may be a matter of opinion, but we are confident, at any rate, that there are some arrangements in the College which should and could be set in better order than they are at present. It seems preposterous, for instance, that in the twentieth century, in one of the largest hospitals of the largest city in the world, rooms should still be lighted by lamps and candles, or, at most, gas. Some of these reforms, we hope, may be effected in the not distant future. Meanwhile, of the two grievances raised by our correspondent, one was obviously merely a temporary inconvenience and need not have been emphasized; the other, the great hot water question, is, we are pleased to hear, to be satisfactorily settled during the next few weeks by a complete overhauling of the heating arrangements.

THE Going-off Dinner was held on the evening of Christmas Day, at the conclusion of the Niggers' round. Mr. H. Lee was elected the new President, and Mr. A. H. Crook the new Vice-President.

THE Annual Dinner of the Guy's Hospital London University Club will be held on Friday, January 28th, at 7.30 p.m. Professor E. H. Starling has promised to take the chair. The dinner will be held, as in former years, at the Trocadero Restaurant, Piccadilly Circus. Members are permitted to bring friends to the dinner, the price of tickets for which is 7s. 6d. each.

A recent number of *The Hospital* contains an interesting interview with our senior consulting surgeon, Mr. Thomas Bryant, on his "Reminis-

cences of Guy's Hospital in the Early Fifties." We quote a passage describing his early days :—

> "I remember Sir Astley Cooper," he remarks, speaking of these old times, "visiting us—he was a frequent visitor at my father's—patting me on the back, and asking me what I was going to do. 'Tom must be a doctor,' he remarked to my father, and I believe that first suggestion put the idea into my head. When my father died I was apprenticed to his successor, who was supposed to teach me and another apprentice; but I learned nothing from him, and left him before my time. Finally I entered Guy's and went through my course there, acting as clinical clerk to Dr. Addison and as dresser to Mr. Aston Key, who was a splendid surgeon. In 1849 I qualified, and then—well then my struggles began."

The article goes on to describe his method of teaching and its success when he was a surgical registrar, and afterwards his experiences as a surgeon in the days before Lister and Florence Nightingale had worked revolutions in two departments of hospital work.

Christmas Week.

The Residents' Theatricals.

THESE were held on Boxing Day and the two following evenings, in the Physiological Theatre. A triple bill was presented on each evening. Messrs. L. E. Bermen, H. M. Woodward, and H. Chapple shared the duties of Stage Manager. No small part of the success of the performances was due to Mr. Crook's work as property master. Mr. J. M. Jarvie acted as accompanist, and played a pianoforte solo during one of the intervals. Messrs. Clive Carey and L. C. D. Irvine sang between the second and third parts.

PART I.

"OLD CRONIES."

By S. THEYRE SMITH.

Dr. Jacks ... ... H. M. WOODWARD.
Captain Pigeon ... ... H. R. MULLINS.
Scene ... Dr. Jacks' Library.

Breezy Captain Pigeon calls on his old friend Dr. Jacks, the lexicographer, for help in compiling a letter offering his hand, heart, and fortune to the lady of his choice. After many amusing but fruitless attempts at composition, they concoct a reply-paid telegram. The reply comes that the lady has accepted one Major Bumble that very day. So far from being upset, Pigeon thinks himself well out of it, and the pair clap one another on the back as old bachelors and old cronies.

Both the characters were really excellently played, possibly at times a little overdone for so small a stage as the Physiological Theatre's, but showing genuine humour. Mr. Woodward has had so much experience of the stage that when we say the honours were equally shared by the two actors, we are giving the highest possible praise to Mr. Mullins.

PART II.

"THE SUICIDE CLUB."

Founded on the Tale by Robert Louis Stevenson, and the play by M.M. Monezy-eon and Armont.

By L. E. BERMEN.

Frank Hartley - - - - - L. E. BERMEN.
The President of the Club - - - H. CHAPPLE.
Bartholomew Malthus - - - - C. H. MILLS.
Jimmy Cassilis - - - - W. H. TRETHOWAN.
Sir Reginald Vandeleur, Bart. - - F. C. ENDEAN.
Dr. Mallett - - - - - W. G. PINCHING.
Oliver Luddington - - - - - H. LEE.
Anatole de Bernia - - - - H. C. LUCEY.
Lord Henry Sinclair - - - - W. E. WALLIS.
Richardson (Club Porter) - - C. M. PLUMPTRE.

It is always a somewhat ambitious experiment to produce a serious play on an occasion of this sort, when a majority of the company have little dramatic experience, and when the audience are frankly out for an evening's hilarity. This being the case, the successful production of the "Suicide Club" is all the more creditable. It was a very serious blow to the Residents when Mr. Renton, who was playing the chief part in the play, suddenly developed scarlet fever, and it was probably an equally great disappointment to Mr. Renton himself. We should like at the outset to express our sympathy with him in the matter, and the hope for his rapid recovery. It is at all times a hard thing to devote time and talent to a thing of this kind, and then never to reap the credit; but from what we have heard of Mr. Renton's performances at rehearsals, he may be congratulated on the fine manner in which he would have played the part had circumstances permitted.

Our sympathy also is with Mr. Bermen, the author of the play, who very kindly took up Mr. Renton's part at the eleventh hour, but would be the first to admit that his absence was a serious disadvantage to the success of the play.

The scene is the Suicide Club, near Craven Street, Strand. Frank Hartley, a young journalist, has heard by chance of the club, and has come to enrol himself under a pseudonym as a new member, and incidentally to glean some sensational copy. After some parley he is accepted by the president, and duly initiated. The members settle down to play the great game in which the cards decide who shall die that night, and who shall do the deed. He who draws the ace of spades is to die, and the ace of clubs decides his murderer. Slowly the president deals round the cards. Several rounds are blank. All the members are on the tiptoe of excitement. Then the old infirm member, Bartholomew Malthus, draws the club ace, and the sudden shock causes his

death. The game goes on. The last card is the ace of spades, and it falls to the journalist. He threatens exposure of the club, and tries to draw his revolver. but is promptly disarmed. The president decides that, as Malthus is dead, Hartley must kill himself. They leave him alone with the revolver and bar all the roads of escape to him ; then they play tricks with the lights, so that the room is now thrown into inky gloom, now illumined by a lurid green. Hartley conjectures that their idea is to drive him mad so that he may then shoot himself. This he therefore pretends to do, and contrives a scream, a thud, and a groan, so as to impose on the listeners outside, while he hides in the window curtains near the door. The president and fellow-members enter, expecting to find a dead man ; instead they are confronted by a live journalist with a loaded revolver, who tells them he is going for the police, makes his escape, locks them in and turns out the light.

Such is the play Mr. Bermen has founded on the tale from the "New Arabian Nights" and on "Les Nuits de Hampton Club," of MM. Monezy-eon and Armont. There is no Prince Florizel in it, alas! But then, who could act that superlative prince? Without him it is of course impossible to get the real Stevenson flavour into the play, but nevertheless Mr. Bermen has produced a genuinely thrilling melodrama, from which he very wisely excluded anything in the nature of farce.

All the parts were well acted. We have already referred to Mr. Bermen's own performance as the journalist, the part which was to have been played by Mr. Renton. Mr. Chapple, as the president, gave us the pleasure of watching a thoroughly sincere and convincing bit of acting, which we appreciated all the more after he had given proof of his versatility by his delightful fooling in "The Spoils of Victory." Mr. Endean's Sir Reginald Vandaleur and Mr. Mills' Malthus were equally excellent. The latter, especially in the difficult bit of acting where he has to die, showed himself to be a very capable actor in melodrama. Of the minor parts, the members of the club, in their varying degrees of blackguardism, were all good. Mr. Lee's acting of Luddington, although he had nothing to say, was a finished study in alcoholic degeneracy. Finally, Mr. Plumptre made a very life-like club porter.

On the first night a section of the audience seemed to have come prepared for farce, and nothing but farce, and the melodramatic thrills of the "Suicide Club" affected them to nothing but uncontrollable laughter. The sight of the club porter, in particular, seemed to be irresistibly amusing. Otherwise, the play was well received on each of the three nights. C.

PART III.

THE SPOILS OF VICTORY.

William Winkle (of Sparrick's Row)	C. H. MILLS.
1st House Physician and President of Residents	W. G. PINCHING.
2nd House Physician	W. JOHNSON.
3rd House Physician	W. E. WALLIS.
A House-Surgeon	H. LEE.
The R.M.O.B.	C. M. PLUMPTRE.
A Patient	L. T. DEAN.
Dr. Moretongue of Colorado	H. F. RENTON.
A Staff Nurse	W. H. TRETHOWAN.
Pro. I (The Public Prosecutor)	A. H. CROOK.
Pro. II.	D. A. MITCHELL.
Pro. III.	H. E. PERKINS.
Pro. IV.	V. TOWNROW.
Sister Camille	H. CHAPPLE.

AND

An Old Foe (let loose for this production) - L. T. DEAN.

Many of the audience, no doubt, witnessed this excellent farce on the occasion of its original production at the Christmas festivities of 1906. It was the first of Mr. Brookhouse's trilogy of clever topical plays. This year Mr. Chapple brought it up to date—the programme modestly has it "mutilated"—by the introduction of many new "gags" and "business." He also introduced a new character, an American, with the inherent characteristics of his race finely travestied. Unfortunately, at the last hour, owing to Mr. Renton's untimely illness, this part had to be cut. Not only did the character add much "go" to the farce, but Mr. Renton's admirable representations of prominent members of the Staff and his make-up and business would have been topics of amusement for some time. At the dress rehearsal the farce gave promise of being the best for many years. As it was, it speaks wonders for the Residents that they could at such short notice—one brief day—readjust the play in such an excellent manner. It was amusing from beginning to end, every character was well played, and the roars of laughter which greeted its merry quips each night were a criterion of its popularity.

For the sake of those who have not seen it, nor read it in book-form, we will give a précis. The first act shows the Residents (Messrs. Johnson, Lee and Wallis) somnolently awaiting the arrival of the Staff. Enter instead Mr. William Winkle (Mr. C. H. Mills), a denizen of Sparrick's Row, with a host of ailments and a Boro' accent that would move a refractory Vanguard. William is sent with his many "cards" in the direction of the Nurses' Home. The re-entry of William with the story of a dire battle in progress gives the Residents their first intelligence of the rising of the nurses—the climax of the Woman's Rights movement; this is supported by the entry of the R.M.O.B. (Mr. Plumptre). Led by the President (Mr. W. Pinching), they all enter the fray, but are ignominiously routed and taken prisoners. The Rule of Woman then commences. Sister Camille (Mr. Chapple) and her five stalwart nurses (Messrs. Trethowan, Crook, Mitchell, Perkins and Townrow) are all-triumphant.

The second act shows us the nurses receiving instruction from the head nurse (Mr. Trethowan). They have now taken supreme control of the Hospital, and Nurse Trethowan, besides telling us of her exploits in the "Front," answers the questions of Probationers Crook,

Mitchell, Perkins and Townrow anent diagnosis and treatment. For a ricked neck, "Ol. Ric. of course; it's pathognomonic. The same drug will do for a squint, only then you call it *castor* oil—so simple," is an example of the instruction these beatific innocents are obtaining. Enter the victorious Sister Camille, who in song tells of the "Superior Sex."

The indefatigable Winkle, now usher, porter and general factotum, with much excellent "business," then arranges the Court Room; the President of the Residents is to be tried for disobedience to the Nursing Staff. Sister Justice Camille takes her seat; the Lady Prosecutrix (Nurse Crook) reads her powerful indictment; the verdict is "guilty; the sentence is an awful one: "He is to ask Sir Cooper to sign a bed-letter on his Wednesday morning round, to pass Mr. Dunn the wrong instrument twice in one operation, to continue to wash up in Hospital Lysol, etc." Verily a dreadful sentence! The President is overcome; all seems lost; but, enter Cupid (Mr. Dean), who, with a few of his barbed darts, plays havoc with the victors' hearts. No longer captives, each Resident is pressed to the manly bosom of his favourite nurse, whilst the militant Sister Camille capitulates to the charms of Usher Winkle and his "Ush."

As Sister Camille, Mr. Chapple once more displayed his well-known talent. His two songs were encored again and again; the two new topical verses in "We anxiously wait for the time," were very popular:—

We have lately acquired a new "front,"
You perhaps will be able to strike it
When you've practised for days in the Hampton Court Maze,
For it's really exceedingly like it!
And the dresser away at one end,
Who's fomenting some Borough brunette's back,
Has a fifty-yard sprint to discover some lint,
And his B.F.'s not H. when he gets back.

And although in the roadway outside
They have altered that paving sublime,
'Twill be many a week ere we hear ourselves speak,
And we anxiously wait for the time.

Now the Matron's been really unwell
Since she witnessed a nursling audacious
Wear an open-work sock, and it's caused such a shock
That she's living on 'light farinaceous!"
She informs us that plainness extreme
And neatness than beauty much better are,
And she'll give us the sack if our hair's not straight back,
And "Remember, you're ladies, *etcetera*!"

So you'd better look hard at me now,
For perhaps when next Christmas bells chime
You no longer will see pretty nurses like me,
And she anxiously waits for the time.

We shall sorely miss Mr. Chapple in future Christmas festivities. His power of organisation, excellent voice and histrionic ability, have done much to make these Christmas plays "go." May we be permitted here also to congratulate him on his skill as a stage-manager.

Mr. C. H. Mills, as Winkle, was indeed humorous; his gagging and business caused great merriment. Especially is he to be praised for the able way he imitated the speech and native traits of a type of Boro-ite that most of us know. His make-up was a revelation. As a head nurse, Mr. Trethowan not only looked, but acted with such maidenly modesty that he really ought very soon to get his "Blue." Messrs. Crook, Mitchell, Perkins, and Townrow were a quartette of demure but muscular Probationers. Their make-up was really excellent, and they ably assisted Sister Camille in both her songs.

Mr. Pinching, as the captive President of the Residents and Prisoner at the Bar, and Messrs. Johnson, Lee, Plumtre, and Wallis as Residents, were all good. Mr. Dean made a captivating Cupid, speaking his lines well, and displaying an agility which belied the size of his wings.

Once again we congratulate the Residents on their excellent show, and endorse what was heard on all sides—that it was a most enjoyable evening. Z.

The Nurses' Entertainment.

In the Nurses' Home, on December 30th, we were privileged to witness an excellent entertainment held in the Dining Hall.

The first part of the programme was provided by the Night Nurses, and was opened by a violin solo by Nurse Grant, accompanied by Nurse Mawson. The next item was a Comedietta; "What will they say at Brompton?" On the eve of a journey to Italy, a Mr. Todd, of Brompton, indulges too freely in some narcotic cigarettes, and dreams a lurid dream of his adventures among Italian brigands. He loses Mrs. Todd in the sea somewhere, is shot through the hat by a brigand, takes shelter in the very same brigand's house, and makes love to the niece. Then the brigands turn up, and Mr. Todd is given the alternatives of death by the pistol, or marriage, followed by death by poison or the dagger. He chooses the latter; then, of course, Mrs. Todd turns up in the inconsequent fashion of dreams. Todd finds himself deserted by everybody, and wakes up from his dream with agonised cries which bring the faithful Mrs. Todd from her slumbers to his aid.

The whole affair makes an amusing enough comedy, somewhat loosely put together, but then, where dreams and brigands are concerned, we cannot afford to be captious. The matter-of-fact Mrs. Todd was very well played by Nurse Calvert, and her nincompoop husband no less well by Nurse Du Boulay. Nurse N. Moore played the part of Miss Croker, an aunt to Mr. Todd, and Nurse Gray played Perks, a maid. The characters in the dream were a delightful medley of dark-complexioned, earringed, whiskered brigandage. Tereboli,

played by Nurse Allen, was a very picturesque brigand, and Marietta, his niece, played by Nurse Strappini, a very picturesque brigand's niece. The smaller parts of Guiseppes, an extra brigand, played by Nurse Tyers, and Grimbaldi, a Major Domo, played by Nurse Foxon, were equally successful in their make-up.

The Second Part, provided by the Day Nurses, opened with some Irish jigs, performed in costume by Nurses Grant, Kenny, Mawson, and Woollett, to the piano accompaniment of Nurse Kingzett. All the dancers showed great accuracy and agility, and Nurses Grant and Kenny especially, in their solo dances, evoked great applause. This was followed by that amusing duologue, "The Crystal Gazer," in which Nurse G. White acted the name-part to perfection. It was a real pleasure to see her don the crystal gazer's mantle, and to hear her don the appropriate foreign accent at the same time. Nurse A. Lloyd played up to her well in the part of the young lady customer.

Nurse Millar then sang a little Irish song in costume, and her splendid voice, though it scarcely had full scope in such a song, so much impressed the audience that they were vociferous in their demands for an encore, which was eventually given. Everybody will hope to hear Nurse Millar again in many future concerts.

The programme concluded with a "Gipsy Troupe," in which Nurses Coulton, Goddard, Lewis, MacManus, R. Miller, Prescott, Sutton, and G. Wallis, took part, and dressed in very picturesque costumes, gave a delightful selection of songs and choruses. The soloists were Nurses Miller, Lewis, MacManus, and Wallis. Our reporter regrets that his position at the back of the hall, and the necessity for gypsies to sit on the floor, combined to prevent his doing justice to the costumes. It must be admitted that the Nurses' Dining Hall is not an ideal place for a dramatic performance. The constant craning of the neck which is necessary in order to get anything like a good view of the stage, is liable seriously to mar one's enjoyment.

At the close of the entertainment, while the audience was partaking of refreshments in the Nurses' Sitting Room, the hall was cleared for dancing. The floor was so thoroughly prepared as to be almost dangerous, but a delightful little dance was held, the only disadvantage being that it was found all too short. Cheers for the Matron at the end gave evidence of the way the entertainment had been enjoyed by the visitors.

Gilbert and Sullivan Concerts.

This party, with an augmented band and chorus, and an extended *répertoire*, again visited nearly all the wards during the week, and everywhere attracted large audiences.

The following is a list of the various items from the Savoy Operas which were performed, new numbers being indicated by a * :—

Mikado.—Madrigal.	"I am so proud."
Gondoliers - -	"In a contemplative fashion."*
	"Try we life long."*
	"Regular Royal Queen."
	"The merriest fellows are we."*
Yeoman of the Guard -	"Tower tomb."
	"A man who would woo."
H.M.S. Pinafore -	"Captain's song."
	"I am the monarch of the sea."*
	"Carefully on tip-toe stealing."
	"Kind captain, I've important information."*
Iolanthe - - -	"When darkly looms the day."*
	"Don't go!"*
	"Faint heart never won fair lady."
Patience - - -	"If Sophia I choose to marry."
Pirates of Penzance	"Hail Poetry."*
	"Policeman's chorus."

*New items since 1908.

The following ladies and gentlemen took part in these concerts. Chorus: Misses *Oram, *Harrison, Mrs. Bent, Misses *Buck, *Billett, *Dusser, *Moore. Messrs. *Carey, *Lobb, *Mitchell, *Peall, *E. W. Blake, G. B. Blake, Lakeman, Trethowan, Johnson, Allan, *Irvine. Band:—Misses Hunt, Oram, Gardiner, and Sayer. Messrs. Hunt and Gardiner.

*Sang in June, 1908.

Queen.

A most delightful concert was given on December 27th in this ward, which looked very pretty for the occasion, with its artistic decorations, a scheme of orange and brown with other autumnal tints most fascinatingly intermixed.

The concert was opened by a splendid selection of songs and melodies by the talented Gilbert and Sullivan party, whose excellent performances are described elsewhere. Mr. Chas. Capper next gave a splendid whistling solo, and later on nobly responded to an encore after his third appearance. Mr. Gardiner then, during the interval for tea, kindly gave a 'cello solo, which was much appreciated.

Nurse R. Miller gave a most fascinating rendering of the "Toreador" song in costume, and later on sang two Japanese songs also in costume, and towards the end sang two Irish songs, all of which were very much appreciated. Mrs. Cornwall very kindly gave a pianoforte solo. Mr. Endean's Village Anthem and Mr. Eccles' humorous contributions evoked uproarious applause. Mr. Mitchell gave an amusing history of two hats and other songs.

The management and patients are very deeply indebted to all those helping to give such an enjoyable afternoon, and especially so to Nurse R. Miller, Mr. Chas. Capper, and the Gilbert and Sullivan party.

Addison.

This concert took place on the afternoon of Tuesday, December 28th, and was in every way a success. One quarter of the ward was turned into a concert room, the Works Department very kindly erecting a special stage for the occasion. The entertainment was divided into two parts. In the first part, or concert proper, Miss Beck and Mr. Waller gave most delightful solos on the violin and piano respectively; Miss Margaret Orr sang charming Irish songs; Miss Mary Orr gave some graceful Spanish Dances in costume, and Mr. Eccles brought down the house with his comic songs.

After tea came a play—"A Case for Eviction"—splendidly acted by the Misses Margaret and Mary Orr, and Mr. G. V. L. Orr.

The proceedings terminated with cheers for those who had so kindly, and so successfully, performed.

Luke and Cornelius.

The above concert was held in the Physiological Theatre on Thursday, December 30th. Mr. Bertie Camplin-Smith, the stage-manager of the Lyric Theatre, had brought down a talented company of ladies and gentlemen, whilst Mr. Leonard Chalk had kindly consented to lead the Lyric orchestra. The patients, who were brought over from the wards, thoroughly enjoyed the concert, especially the orchestral selections. Miss Lillian Braithwaite delighted all with her charming recitations, and Miss Helen Mar's stories were received with much laughter and applause.

The Court Glee Singers contributed two excellent numbers, a glee extolling a wonderful quack remedy being very humorous. One of the gems of the afternoon was the orchestral selection, "A Southern Wedding," a piece descriptive of the function in Coonland; the bassoon, representing the parson's voice, elicited great mirth from the audience.

Miss Bessie Abelson, a powerful contralto, sang "My Ain Scottish Hame" with much feeling, whilst Miss Heath, a charming soprano, delighted all in a light ballad. Mr. Jack Phillip's Toreador song from *Carmen*, and Mr. Alec Thompson's humorous songs, well deserved their encores. Mr. Napper performed a sketch illustrative of a bashful lover's wiles in effecting a reconciliation with his lady-love, and Mr. Nelson Keys brought joy to the kiddies' hearts with his wonderful impersonations of a child practising the piano and reciting. A violin solo by Mr. Windeatt was tastefully rendered. Mr. Archibald Evans was at the piano.

The thanks of all are due to these talented ladies and gentlemen for an afternoon which was enjoyed, not only by the patients, but also by the numerous audience of nurses and students. Sir Alfred Fripp was instrumental in bringing about the concert, and once again are we indebted to him. Mr. Camplin-Smith went to no little trouble to organise the concert, and we assure him his efforts were enjoyed to the utmost.

Charity.

On Friday, the 31st December, Mr. Henry Ainley and a party including Miss Suzanne Sheldon, Miss Marie Brema, Lady Speyer, Miss Myra Hess, Mr. Sam Walsh, and Mr. Byrd Page, came down to Charity and gave us a splendid concert. It would be superfluous, after reading the above names, to enlarge on the excellence of the concert. Suffice it to say that it was one of the best of many given here this Christmas. We wish to thank Mr. Ainley and the others, on behalf of patients and Hospital, for so generously coming down and helping us, especially at this their busiest time of the year.

Esther.

A concert was held at 3 p.m. on Friday, December 31st, in Esther ward, when Miss Marie Löhr and some friends gave a most enjoyable entertainment.

Miss Löhr, on her arrival, brought with her oranges and bunches of violets, and by distributing them herself gave much pleasure to the patients who were present. Miss Marie Löhr, in a voice which is sweet and dainty, sang "My Wish," "Eyes that used to gaze in mine," and "If I had a Dolly," the latter of which is composed by her mother, as well as two duets with Mrs. Hermann Löhr, and the applause which she received expressed admiration for her singing as well as thanks for her kindness in coming.

Mrs. Hermann Löhr, who has a charming contralto voice, and Miss Esmé Hubbard in her character songs, were much appreciated, while Miss Madge Titheradge in her recitations gave evidence of her great ability both as actress and elocutionist. Mr. Curtiss gave some delightfully humorous recitations. Mr. Frederick Narton's comic songs sung at the piano were a great success, in particular "George's Love Affair," which was written and composed by himself, and caused much laughter. The accompaniments were played by Mr. Hermann Löhr, who also actively and nimbly acted as M.C. Sister had provided an excellent tea, and both patients (of whom a large number were present) and visitors were sorry when the concert was ended. To the artistes who took part and to Dr. Rippmann, who arranged the concert, our best thanks are due, and we trust that we may have the pleasure of seeing Miss Marie Löhr amongst us often in the future.

Patience and Samaritan.

The Patience and Samaritan concert took place on Friday, December 31st, starting punctually at 3 p.m. The patients enjoyed the programme very much, and wish to thank all the kind people who gave their services for the afternoon.

The ladies who sang were:—Mrs. Cadman, Miss Alys Rees, Miss Davies, Miss Hughes, Miss Pheysey, Miss Evans, Miss Marshall and Miss Cable. Mrs. Harvey, who was indisposed, was unable to come.

Among the gentlemen who sang were:—Mr. Stott, Mr. Ryley, Mr. Henning, Mr. Irvine, Mr. Carey, Mr. Constant, Mr. Victor. Mr. Roche, the ventriloquist,

was loudly cheered, especially by the children. Mr. Middlemas, violinist, and Mr. Lucey, who played the concertina, were greatly appreciated.

Many thanks are due to Miss Ainsworth and Mr. Gardner, who acted as accompanists. In the interval Sister provided tea, which was enjoyed by both patients and visitors. Nurses, dressers and clerks all helped in various ways towards the success of an undoubtedly good concert.

Mary.

At this concert, which took place on the afternoon of Friday, December 31st, little Miss Iris Hawkins was the chief attraction. Messrs. Bellew and Stock were kind enough to bring down a merry gang of little girls—the "Romps"—who sang and danced with considerable spirit to the vast delight of a big audience, Miss Hawkins herself coming on with a song and dance at the finish as a grand finale. Messrs. Johnson and Stock gave songs and humorous recitations, the latter drawing some very hearty laughter, while everybody thoroughly appreciated "Songs of Araby." Unfortunately the party were unavoidably delayed and arrived considerably later than they had originally intended. However, thanks to the kindness of many local favourites, the interval was easily filled. Nurse Lewis and Messrs. Carey, Endean, Lobb, Eccles and Irvine all sang, and we are sure that those who were fortunate enough to be present will consider this by no means the least enjoyable part of the programme.

Job.

The Job concert was a complete success, although three of the outside performers were unable to turn up. The programme was opened with a piano solo by Mr. Jarvie, excellently rendered by that eminent Scottish surgeon. Mr. Carey then sang two songs, which were much appreciated.

Miss Viva Birkett, of the Vaudeville Theatre, then gave a very amusing monologue, followed by a duet, in which she was joined by her sister. Miss Christina Birkett, who has a beautiful contralto voice, then sang a solo, which was encored.

The next item was a concertina solo by Mr. Lucey, accompanied on the piano by Mr. Jarvie. This proved a great surprise to most of the company, and showed what a delightful instrument the concertina can be when well played. Miss Hodgson Stevens then sang a song, entitled "Our Farm," which was encored.

Mr. Harry Welchman, of the "Arcadians," next sang two songs. He has a very fine baritone voice and was heartily encored by patients and visitors. Mr. Peall was good enough to sing next, although he had been singing all the afternoon in the Gilbert and Sullivan troupe. Unfortunately he had to go almost at once, so could not give an encore.

After the tea interval, Mr. Endean, who, although in great request this Christmas, has always complied to every demand on his voice, gave us a song called "A Clinking Toast," which was uproariously encored. He then gave a few selections of his own composition, accompanying himself on the piano. The first told us a harrowing tale of a stormy night, of a fisherman (who must go fishing, although he doesn't know why), and the fisherman's wife and baby, and a villain. The next was the ever delightful, "The Village Anthem," and the next was the story of a fortune won on the racecourse as told by a man with a cleft palate.

Miss Davies next gave two songs, which were encored, and the programme ended with a selection of songs and duets by Mr. Parks and his friends. These were heartily enjoyed by the patients and visitors, and we were sorry not to be able to have more of them.

Our best thanks are due to all the contributors to this excellent concert for the most pleasant way in which they responded to encores.

Astley Cooper.

The Astley Cooper Concert was held, as usual, on the last day of Christmas week, and was a roaring success in every sense. All the singers were Guy's men, and all the songs were familiar to everybody, so that many of the choruses were sung by the audience with great spirit, and nearly all the performers were encored. It was especially pleasing to welcome some old friends, both in singers and songs. Among them was Mr. P. S. Price, who sang the traditional "Four 'Oss Charrybang," and as an encore, "Chorus, Gentlemen," and, later, delighted his hearers with some of his imitations of the Staff, and Mr. E. M. Ball, who sang two comic songs. Mr. Mullins' song, "When I was a lad . . . etc.," also aroused memories of past Christmases. Mr. Duvivier gave several clever imitations of operatic selections on a gramophone; Mr. Peall sang two sentimental songs; Mr. Kidd sang a version of "Mandalay." Messrs. Irvine, Ryley, Johnston, Martyn Lobb, Eccles, and Mitchell all sang with great success, in several instances in costume, and in every case with a demand for more from an enthusiastic section of the audience. Messrs. Evans, Johnson, Endean, Pryce Davies, and Lee sang their respective songs from the Niggers' programme, and repeated their triumphs of the previous week. Mr. Crook sang his song—it is unnecessary to particularize. Mr. Endean also gave "Kissing Cup's Race" and other favourites from his repertoire. Mr. Trethowan sang a nigger song, and afterwards concluded the concert with "Good-night." Cheers and counter-cheers and "Auld Lang Syne" and "God Save the King" brought to a close the last and jolliest concert of Christmas week.

Notice.

Dental Surgeons in the Royal Navy.

Vacancies for Dental Surgeons, aged 21–28 years, for duty with the Naval Forces in the United Kingdom are being advertised in the *Lancet*, *British Medical Journal*, *British Dental Journal*, *Edinburgh Medical Journal*, and *Dublin Journal of Medical Science*. Pay, £1 per diem.

Constipation.

CLINICAL LECTURE BY DR. HALE WHITE.

GENTLEMEN,—As you are aware, I am now in charge of the Clinical wards, and there we are so frequently confronted with the problem of how to treat a patient who is constipated, that I thought we might profitably deal this afternoon with a few aspects of this very large subject. The first thing that ought to exercise our minds when we are face to face with a patient who is constipated is the possibility that he is suffering from serious abdominal disease which requires immediate surgical interference. Only last night, in the Miriam ward, a child was brought in whose bowels had not been opened for forty-eight hours Of course, the parents knew nothing about the abdominal rigidity, and, so far as they could tell, the stoppage of the bowels was the most prominent symptom of the case. On examination it was found that the child was suffering from acute peritonitis, and she was operated upon at once. This problem of constipation in association with serious abdominal disease is constantly coming before us. It is essential to remember that if the medical man in charge of the patient does not make sure at once whether or not it is a case for immediate surgical interference he runs grave risk of losing his patient's life. Many lives are lost, indeed, because the patients are sent in here too late. If the cases that we take in the John and Miriam wards were only brought to us much earlier, we could save more lives than we do. The misfortune is that during the first forty-eight hours or so the condition is thought to be one of ordinary constipation. Aperients are given, which do not serve to unlock the bowel, and therefore the case is sent up here. In this way not only has valuable time been lost, but actual harm has been done by reason of the aperients that have been given. I have calculated that in a case of acute peritonitis, due to perforated gastric ulcer, every hour for which the operation is delayed increases the mortality by about 3 per cent. Therefore it does not require very long for the mortality to mount up to a very high figure.

The acute diseases in which constipation is a prominent symptom include acute general peritonitis, various acute affections associated with disease of the appendix, and internal strangulations, such as that by a band. In all these cases, if there is delay, the patient's chances of recovery are greatly lessened. For this reason we have to ask ourselves, when looking at a case of constipation: Is this one of those cases which demand surgical interference at once?

But it is not only acute cases that trouble us in this way. There are various chronic diseases of the abdomen which surgery can benefit, and of which constipation is a prominent feature. Many people have slight attacks of appendicitis, and when the appendix is removed the constipation which accompanies the condition passes away. Such cases are not so common, I think, as some writers would make out, but, still, they are fairly frequently seen, and sometimes the constipation is treated for a long period, whereas a comparatively simple operation would have got rid of the abdominal pain and of the constipation also. Then think of the cases of malignant growth. Most people who have carcinoma of their bowels are, for a long while, treated as sufferers from ordinary constipation. This is a most harmful mistake to make, because the irritation which is set up by the purgatives does not do the growths any good. If we are to make our patient permanently free from malignant disease of the bowel, the only thing to do is to excise the growth at a very early stage. But the growth is often not capable of excision, because we have overlooked the possibility of malignant growth as the cause of the constipation. Sometimes the growth in the bowel is not malignant. I saw a man this autumn who was suffering from chronic constipation. There was a thickening in the pelvic colon and the iliac colon, and an operation showed that the cause of the obstruction was chronic inflammation around the sigmoid, with matting of the bowel. That man did well after operation by Mr. Rowlands. Sometimes people with chronic constipation owe their trouble to tubercular disease of the bowel. Some of the lumps which are often felt in the cæcal region are really due to tubercular disease of the cæcum. The mass can be removed, or a short-circuiting operation can be done. I recall a remarkable case of a man in Addison ward, who had had constipation for some time with abdominal pain, and when the abdomen was opened by Mr. Steward, nine cicatrising ulcers, tubercular in nature, were found in the lower four feet of the ileum. This was a case which might easily have been treated as one of chronic constipation. There would then have been gradual obstruction, and the patient would have died, whereas now a short circuiting operation will, I hope, relieve him. Various tumours in the pelvis amenable to surgical operation may

be the cause of constipation. Some people have been treated for months and years for ordinary constipation when they have had tumours or stricture in the rectum. If there is any doubt, an examination should be made with the sigmoidoscope. Similarly with painful fissure of the anus, a comparatively small operation would get the patient out of his difficulty, whereas no amount of ordinary treatment for constipation would remove it. Unless, therefore, a medical man is sure at first sight that a case of constipation is obviously a simple one, he should never omit to examine the abdomen, and in most cases the rectum. If the rectum is empty and ballooned it is extremely probable that there is intestinal obstruction.

In John ward, about four or five years ago, a boy was brought in for constipation. As a matter of routine I examined the rectum, and found a piece of coal. After further investigation we were able to scoop out from the rectum nearly a pound of small coal. I think it must have been pushed in at the anus, for there were no fæces mixed with it. What heroic purgatives that boy would have required if he had been treated as an ordinary case of constipation without rectal examination! Gall-stones will also block the bowel. When they do so they ulcerate straight from the gall bladder into the bowel, which they block about eighteen inches above the ileo-cæcal valve.

Again, as you know, impacted fæces will block up the bowel and produce tumours of enormous size. In a case, which had been sent by the doctor as one of tumour in the kidney, the tumour due to impacted fæces was large enough to press upon the sacral plexus and give the patient sciatica, which remained for some time after the intestinal condition had disappeared. In these cases, when it is not possible to get in an enema, it is best to give an anæsthetic, and to scoop the fæces away, afterwards—as an enema small in bulk is desirable—administering glycerin or 40 or 50 grains of ox-gall dissolved in a little water.

I quite admit that what I have said about these cases that can be dealt with surgically fails to apply to the great majority of cases of constipation, but I have insisted upon this aspect of the matter because it is such a terrible mistake to overlook it. Our attitude ought to be: Is this a case in which surgical interference can do some good? The surgical interference need not necessarily be directed to completely removing the obstruction. But it is desirable to diagnose malignant growths; for example, even if they cannot be excised it is possible to do a short-circuiting operation. On all grounds it is essential that the diagnosis should be made as early as possible.

Supposing the organic obstruction is such that no surgical operation is feasible, you can benefit the patient by a judicious choice of an aperient; remember that the gut is narrowed by the obstruction, therefore you want the fæces to be small and fluid. In that case there is no better purgative than jalap. If jalap irritates the patient give castor oil. There is another serious organic abdominal condition associated with constipation, which, however, is not amenable to surgery. One of the most remarkable things in medicine is the small extent to which, in many cases, chronic peritonitis interferes with the movements of the bowel. In simple or tubercular peritonitis it may be possible to take out the whole of the intestine in one mass, matted together with peritoneal adhesions. Yet, in spite of this state of affairs, some sufferers from chronic peritonitis have scarcely any constipation at all. I have no idea as to how peristalsis takes place. If constipation is present, jalap, castor oil, or salines are the best things to give. Chronic constipation is also a frequent accompaniment of another serious condition, namely, gastric or duodenal ulcer. The best treatment for these ulcers is to give the patient plenty of olive oil in the diet, because the oil inhibits the secretion of the gastric juice, is highly nutritious, and is the best means of treating the chronic constipation.

We have further to remember that in some patients the constipation may be due to drugs. Patients who take iron or bismuth or opium are constipated. The same is true of most opium-eaters. Again, some people's constipation is due to excessive indulgence in strong tea. The large amount of tannin in the tea may cause considerable constipation. Sufferers from lead-poisoning are usually constipated. Then constipation is frequently due to errors of diet, particularly to the fact that a patient does not take enough bulk of food. This is the case with a patient who is on a milk diet. Those who suffer from anorexia nervosa are naturally constipated, for they take little food. In fever, when patients are on an allowance of 2½ pints of milk in the twenty-four hours, I do not think that the constipation is solely due to the small allowance of food, for they are often constipated before they are put upon a restricted diet. There is some hidden cause for the constipation associated with pyrexia of which we know little. It is a routine practice in some large institutions where there are many cases of typhoid fever to give an olive-oil injection per rectum every second

day, unless the patient's bowels are open every day. In speaking of diet, it is necessary to remember that a cause of constipation is the taking of an insufficient quantity of vegetables and fruits, so that there is not sufficient bulk of fæces to provoke the usual muscular action. Vegetables are valuable irritants to peristalsis. White bread is more likely to constipate than whole-meal bread. In white bread the bran, which is of so much use in stimulating peristalsis, is taken away. Many people overcome slight constipation by drinking a glass of cold water when they rise in the morning. This reflexly stimulates the bowels to act. Constipated people should take a large amount of fruit, especially baked apples and prunes, almost any vegetables, and also porridge. Tamarinds are most useful in cases of constipation, and may be spread on toast like marmalade.

I may add at this point that there are some conditions in which it is particularly necessary that the patient should never be constipated, because if he is constipated he will strain when the bowels are open. One good instance is that of thrombosis of a vein. The father of one of our students here, was seized with acute pain in the leg while travelling to London. His son met him at Euston, and, seeing that something serious was the matter, took him to a neighbouring hotel. On examining him, I found that he had thrombosis of his femoral vein. We kept him in bed, and impressed upon him particularly that he was never to strain. After being in bed for three weeks, he felt so much better that he did strain at stool, and he got a fatal pulmonary embolism in consequence. It is also important not to strain in acute pericarditis, as when a person strains he raises his blood-pressure, and so may dilate the inflamed heart. The same thing applies, of course, to an aneurysm. In all these cases it is important to have the bowels kept open gently every day. This matter will require special care in pericarditis, as, in that condition, it is rightly customary to give opium, which has a constipating effect. A considerable proportion of the cases of cerebral hæmorrhage occur while the person is straining to make his bowels act, and thus not rarely the cerebral hæmorrhage takes place in the water closet. A little calomel at night, followed by any saline mineral water in the morning, should be given to those who are subject to high blood-pressure, or are, for any other cause, liable to cerebral hæmorrhage, so that they may pass an easy motion. If the cerebral hæmorrhage has already occurred, and the patient is unconscious, as he often is, and therefore cannot swallow easily, the best thing to do is to give him a powerful aperient in a small bulk. A drop of croton oil, placed at the back of his tongue, and mixed with a piece of butter to prevent its inflaming the tongue, will be swallowed involuntarily, and will help to lower the blood-pressure because it opens the bowels. If there has been hæmoptysis, a large dose of sulphate of soda, or other purgative—it does not matter much what purgative—may be given for the same reason. In cases of chronic uræmia, also, it is necessary to keep the bowels well open. We do not know what the poison is in uræmia; we cannot neutralise it in any way, and therefore we are driven to keep every eliminative channel free. It is not a bad thing to give such patients a good dose of saline every morning when they wake up. Women suffering from chlorosis are constipated, and they usually require an aperient.

A large group of the people who are constipated are those past middle life, who eat too much and take too little exercise. They are told to eat less and to take more exercise, but sometimes they will not, and at other times they cannot. Such people do not do badly if they take a mild aperient every day or every other day of their lives. In such cases they may take after dinner a pill containing a quarter of a grain of each of calomel, extract of euonymin and extract of nux vomica. This is the class of person who, if he can afford it, takes a holiday at some place where there are saline springs, and drinks the waters at Cheltenham, or, if he likes to go abroad, drinks the waters of Carlsbad, Marienbad, Kissingen, or Homburg. So far as I know, he would do just as well if he drank the water at home, but the probability is that he will drink the water much more regularly if he has to go three or four hundred miles to do so.

Another numerous class of constipated people is composed of women who come before us with this as their only complaint. With many of them the cause of the constipation is complex; there is more than one cause in the case of each patient. With some the constipation is due to faulty bringing up. Children should be strictly trained when young to endeavour to empty the bowels at the same time regularly every day. Another cause is the failure to go to the water-closet when there is a call to do so. This remark applies to many women, also to business men who are in a hurry to catch the early morning train, and to boys rushing off to school. Again, some of these people drink too little. That is a contributory cause with many

women, who dislike frequently emptying the bladder. Too little fluid involves a drying of the fæces. Many women, from vanity or other cause, eat too little. Others have no appetite, and this brings us to the border-line of the group of persons who have anorexia nervosa, which sets up constipation because there is too small a bulk of fæces. But when we have considered all these contributory causes, the most important factor inducing constipation in the class about which we are now talking is poor general health. As a consequence of that poor state of general health the muscular power is diminished, and as the diminution of muscular power is not generally limited to one part, the abdominal and intestinal muscles share in the general enfeeblement. It is this poor general health, leading to deficient abdominal and intestinal muscular power, that is the important factor to be considered in these common cases of constipation in women. The diaphragm also is most important to defæcation, and in general ill-health there probably is, as a rule, diaphragmatic weakness. Then, again, repeated pregnancies weaken the abdominal muscles and so induce constipation. Nothing weakens a muscle so much as stretching it. The muscles are stretched in pregnancy, and the poor woman never thoroughly recovers the proper strength of the muscles of the abdomen and those of the floor of the pelvis. Sometimes the failure to contract the muscles properly has a cause located in the chest. A sufferer from disease of the heart or of the lungs, with shortness of breath, cannot bring about proper muscular contraction of the abdomen nor induce pressure sufficient properly to open the bowels. Old people sometimes owe their constipation to this general weakness of the muscular system, and it is also one of the most important factors of the constipation that occurs in chlorosis, cancer, and tubercular disease. In passing, I should like to remind you that a weakness of the abdominal muscles leads to a dropping of some of the viscera, and constipation is often set down to visceroptosis, but that is not the case. The constipation is due to the weakness of the muscles that cannot properly contract.

Unless there is some disease, *e.g.*, heart disease, to prevent it, the treatment should be as follows:—In the first place, an alteration in the patient's diet on the lines already mentioned. In the second place, the adoption of some form of outdoor exercise, walking, golfing, or anything that she prefers. She must be made to lead a healthier general life, and while the muscles are so weak she may be given some simple aperient to keep the bowels open. A daily pill of cascara sagrada and extract of nux vomica is useful. But all this is worth nothing without some means of developing the failing muscles. Such patients should have their abdominal muscles massaged. The massage should be given before the patient rises in the morning, and should last for about fifteen or twenty minutes, being confined principally to the abdomen. If twenty minutes' massage be given, it might be applied for fifteen minutes on the abdomen and for five minutes on the rest of the body. The masseur should also put the patient through a course of exercises such as lying on the floor and getting up without using the hands, which help to strengthen the abdominal muscles. A skilled masseur in these ways can rapidly increase the bulk and strength of the abdominal muscles. Each morning, when the massage is over, the patient lies still for a short time and then rises, has a bath and breakfast. If this treatment be carried out persistently for several weeks the beneficial results that will follow will be surprising, and the aperient will soon be reduced and finally abandoned. Further, the patient will remain well. I have seen women who have remained well although this treatment was carried out twenty years before. If the expense of massage is prohibitive, the patient may, it is said, develop her abdominal muscles by self massage, carried out by rolling a cannon ball covered with leather over the abdomen. Of course, if there is underlying disease, such as chlorosis, this must be treated at the same time.

In some cases the fæces collect in the rectum, and not above it, as is usually the case; even then, however, massage of the abdomen is of great use by increasing the force of the expelling muscles, but instead of giving an aperient by the mouth, we may give an enema and diminish the amount every day. As soon as possible the patient ought to give up the use of enemata. The discomfort is so great that it is worth a great deal to get the patient out of the practice. Some people are tied to their own home, and cannot go out visiting or stay at an hotel, because of the necessity of using an enema.

To come now to the question as to whether there are any cases of ordinary constipation which are so bad as to require surgical interference. I may say that I have never seen such a case. The cases that cannot be remedied by the methods I have outlined are very few—at all events, if the treatment is persisted in long enough. Some cases at first appear to fail although massaged. If this is so, let the masseurs not only use massage, but at the same

time teach the patients various exercises which develop the abdominal muscles. A very good one is to lie flat on the floor and get up again without using the hands, but there are many others. Various forms of Swedish exercises are useful. I think you will find the cases of constipation we are now considering very few and virtually negligible in which you cannot obtain a cure by these methods.

It is said that sometimes constipation is due to adhesions which form around the bowel and so prevent its proper action. Well, in the post-mortem room here, Messrs. Mollison and Cameron showed that such an enormous number of people have adhesions that if adhesions were to cause constipation it would be infinitely commoner than it is. As I have already said, in a case of chronic peritonitis there may be adhesions as thick as the finger, suggesting that plaster of Paris had been poured around the intestines, without any constipation at all. Furthermore, if they are removed they form again, so please do not attempt to treat constipation by opening the abdomen and dividing adhesions. Then, as you know, short-circuiting operations have been proposed, but as in such cases the ileum cannot be implanted into the large bowel below the collection of fæces, such an operation is faulty in design. Then it has been proposed to excise the colon, but I do not think I need go into that, because excision of the large bowel is an operation which could only be undertaken by surgeons of exceptional skill; it has a considerable mortality, and, after all, these cases of chronic constipation are not fatal. For my own part, I have never seen a case in which I believed it would be advisable to remove the large bowel for chronic constipation, and I do not recommend you to embark upon such a formidable operation. You will find all the arguments for and against this operation given by Dr. Hertz in his recent book on constipation. Another operation that has been suggested is to open the appendix, pour in fluid, and so wash the fæces out. That proceeds upon a false idea as to the action of an enema. When we introduce soap and water into the rectum it sets up contraction of the bowel above the fæcal block, and I do not see what is to be gained by opening the appendix and putting the fluid on the other side of the fæces.

Finally, it does not follow that a patient is constipated if the bowels are not open once a day. Many people can go for two, three, four, or even five days without the bowels being opened. They do not necessarily require any treatment. We only require to treat people for constipation when we find that there is something the matter with them which impairs their health, and may be set down to the non-action of the bowels. People who suffer from constipation frequently are subject to indigestion, irritability of temper, lassitude, a feeling of distension, and a loss of appetite. In that case they may be treated for constipation. Or, of course, treatment may be necessary for some special condition, such as uræmia or pericarditis. I would also remind you that sometimes constipation is present, although the patient does not realise it It stands to reason that if, on each visit to the water closet, three-quarters only of the fæcal matter that ought to come away is evacuated the person must be constipated, even though his bowels appear to be working quite regularly.

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

Hodgkin and Sir Moses Montefiore.

DEAR SIR,—*On reading the story of Dr. Hodgkin in* your last number, where I say that his death occurred during the last visit of himself and Sir Moses Montefiore to the Holy Land, I ought to have added the word "together," because Sir Moses, when a very old man, several years afterwards, made another journey to Palestine, hearing that troubles had occurred at an institution at Jerusalem supported by himself and Lord Rothschild. On this occasion he had an easier journey than formerly, going by the route to India by Paris, Turin and Brindisi, and then by steamer to Alexandria and Port Said. He then proceeded in an Austrian vessel going to Jaffa and Beyrout. On arrival at Jaffa in the evening a large number of friends were waiting to greet him, one of whom had prepared a house for him to lodge in. On the following morning, he says in his narrative, his friend having lent him a carriage, "it conveyed me first to visit the tomb of my much-lamented friend Dr. Hodgkin." Having to wait four days at Jaffa to prepare for his visit, not liking to encamp three or four nights on the road to Jerusalem, he says, "I went to see again the tomb of my much-lamented friend Dr. Hodgkin, and arranged that, for the better preservation of the ground, a suitable railing should be made round the monument. It was a melancholy occasion, and made me remember all those virtues by which the departed was so pre-eminently distinguished during his life."

Sir Moses, knowing I was much interested in Dr. Hodgkin as the first curator of our museum, and therefore was well acquainted with his travelling in the East with Sir Moses, sent me a copy of his book containing an account of his last visit to Palestine, and it is from this book that I make the extracts which I have just quoted. He sent it to me with his name written on the title-page, and a faded photograph, fixed on the outside cover, of himself and his wife. I am now sending you this book, with the request that you will hand it to the librarian, to be placed on some shelf of the library, where it will remain as a memento of Dr. Hodgkin. It will remind the reader, also, of the course of his life after he bade farewell to Guy's, when he lost the promotion which he so much coveted. During the time he was curator he was clean-shaven, and therefore his portrait which you gave in the GAZETTE was the most apposite; but he afterwards wore a beard, which, I think, very much improved him. A photograph of him at this time I also send you to be placed with some other mementoes of the Guy's staff and professors.

I cannot say what first brought about the close association of our hospital with the Montefiore family, but in my early student days a young man, named Nathaniel Montefiore, came as a volunteer to study medical subjects and, more especially, physiology, so that some years afterwards he used to come down to Dr. Pavy's laboratory and see his experiments in connection with diabetes. He rented a room in the small house of the porter's at the lodge, named Archer. It was situated, if I remember rightly, in St. Thomas' Street, at the back of the corner house, near the old burial ground behind the chapel. Montefiore was evidently very popular with the students, who used to call him "Nat."

I believe his sister married a Goldsmid, but of this I am not sure; she having died early, a child's hospital was built to her memory in the Southwark Bridge Road, and called after her name "Evelina." I believe the first members of the staff which were appointed were Guy's men. Some years afterwards Montefiore had a very promising and learned son; he, unfortunately, died young, which was a great distress to his father, and no doubt it was, in fact, the reason why he succumbed to some abdominal disease. I was called to see him, but being away from home Dr. Fagge went as my substitute, and was present at his death.—I am, etc.,

SAMUEL WILKS.

[The book and photograph which Sir Samuel Wilks has kindly sent, referred to in the above letter, may be seen in the library by anyone interested in the subject. With reference to Hodgkin's growing a beard during one of his journeys in the East, Sir Samuel Wilks adds:—"The GUY'S GAZETTE was, I believe, at that time in its infancy, but in all probability the Editor had a collaborator who wrote in the 'Lighter Vein;' no doubt, however, there was always amongst the students the 'funny man.' This gentleman was guilty of giving birth to the following *jeu d'esprit:* 'Hodgkin went out with Moses and returned with Aaron (hair-on).'"—ED.]

Politics Again!

DEAR SIR,—As the GAZETTE is going to press, an event has occurred which has aroused much indignation amongst many hospital men. A party meeting in support of the Conservative Candidate for Rotherhithe was announced, and held in the College Smoking Room, without the wishes of the Clubs' Union having been consulted. We think, particularly in view of the recent controversy *re* the Bermondsey Election, that the holding of any such party meeting in the Guy's Hospital Club is particularly regrettable and unfortunate. One wonders that the Warden of the College should have thought fit to lend a room and his presence without previous consultation with the Clubs' Union Committee. Our protest is not dictated by political views, but is directed against the principle of connecting the Hospital men in general with any party, and we would suggest that a meeting of the Clubs' Union be held to obviate any such occurrence in the future. Time prevents our saying more on the matter; but no doubt the next issue of the GAZETTE will contain further evidence of the indignation which the organization of such a meeting has aroused.—We remain, &c.,

J. A. RYLE,
E. G. SCHLESINGER.

The College, Guy's Hospital, S.E.
January 7th, 1910.

Emboli.

WE hear that the Passimist had quite a nice flowery paragraph ready written to congratulate Mr. Fremantle on winning the Rotherhithe seat, and that it has had to be scrapped owing to that gentleman's unavoidable retirement.

People are beginning to forget that the Choral Society ever had its pre-Careyious days.

Some readers seem to be under the impression that a letter headed "College Amenities," which appeared in our last issue, emanated from the Deputy-Warden of the College, as it was signed RIP. We hasten to correct the impression. Neither the Warden nor the Dean had any hand in it.

Meanwhile, New Year resolutions have had such a good effect on residents in the College that they never get into hot water now. It's so difficult to do it!

"In deference to aseptic principle, no holly was used in the decoration of the wards at St. Thomas' Hospital."—*Daily Paper.*

At Guy's, we are happy to say, we were quite unprincipled in this matter. Even mistletoe was used, and that is much more dangerous than holly.

A highly novel scheme of decoration was adopted in some wards. Festoons of ivy were hung across the ceilings, and down to the beds. The effect was thought to be at once novel and artistic.

Some of the Nuts, we hear, came wonderfully out of their shells on Bonfire night, and broached a barrel of Nut Oil, which they used to toast themselves and their friends with—in the quad.

CONSTANT READER.

In Clinical.

BY R. P. ROWLANDS, M.S.

GALL-STONES.

CASE 1.—A woman came in deeply jaundiced, with a fortnight's history of severe colic and increasing jaundice, and towards the end some fever, which was associated with rigors. Years earlier she had passed a gall-stone, which was so large that it must have ulcerated from the gall-bladder into the bowel. There was no enlargement of the gall-bladder. A diagnosis of stone in the common duct was made, and an immediate exploration was undertaken. There were a great many adhesions between the duodenum and the shrunken and empty gall-bladder. With some difficulty these were separated and the small omentum was discovered: it was unusually thick and fatty, and the foramen of Winslow was occluded. The fingers of the left hand were passed in this direction, and the omentum clasped between them and the left thumb. A large stone was felt behind the duodenum, and pushed back into the first part of the common duct, while the peritoneum and the duct were incised longitudinally over the calculus, which was removed with suitable forceps. A finger was introduced into the duct and passed upwards to explore the dilated hepatic ducts, and downwards along the common duct, with a negative result. A small tube was then passed into the common duct and fixed in position with a fine catgut suture passed through the peritoneal covering of the duct only. This tube was long enough to drain into a bag at the patient's side. Some thin bile and muco-pus had escaped from the duct. The pack was removed from the kidney pouch, and a large rubber tube containing a gauze wick was passed into this pouch. The lower and greater part of the wound was then closed in layers. The patient was kept lying flat for two days, and then placed in the semi-sitting position. The large tube was removed on the 5th day, and the small one on the 10th day. The bile ceased to leak at the end of a fortnight, and the patient went out well five weeks after the operation.

CASE 2.—This was a very stout man with chronic bronchitis, with a history of colic in the biliary region for years. During the last three months he had been rarely quite free from pain and jaundice for more than a few days. While in the hospital he had a shivering fit. He was explored through the usual vertical incision curved inwards at its upper end, and dividing some of the fibres of the rectus muscle. After packing the kidney-pouch, and protecting the stomach and intestines with a large flat pad, a stone was felt at the duodenal papilla. In spite of all efforts to press it back into the first part of the duct, it remained firmly impacted. The peritoneum to the right of the duodenum was incised, so that the bowel was liberated sufficiently to allow it to be brought well into view. An intestinal clamp was applied across the first part of the duodenum and the common bile duct behind it. The stone was grasped between the finger and thumb, and pushed well up against the anterior wall of the duodenum. This was incised in a vertical direction directly over the stone, and just above the attachment of the meso-colon. The stone, impacted in the posterior wall of the duodenum, was pressed through the aperture thus made, and seen firmly fixed in the ampulla of Vater, a little of it being visible at the papilla. The mucous membrane covering it was incised upwards along the duct from the orifice, and the stone was easily removed. Then the wound in the anterior wall of the duodenum was closed by a through and through suture of silk, care being taken to place the knots inside the bowel, and, reinforced by a sero-muscular suture of finer silk, a tag of the meso-colon was also sewn over the incision. Then the clamp was removed. The gall-bladder, which had been distended, emptied itself into the duodenum. It was then opened, but no stones were found in it, or in the cystic duct. A tube was sewn into the inverted edges of the wound in the gall-bladder, and a large tube containing a wick of gauze was used to drain the kidney-pouch, care being taken to place the tube well away from the sutures in the duodenum. The wound was then closed. The patient was kept on water for two days, and then the diet was gradually increased. In spite of bronchitis the man made a good recovery. Three months later he came to show himself at Out-patients, and was quite well in every way. There was some difficulty in getting the bowels to act about a week after the operation. An ordinary enemata having failed, an enema of ox-gall was administered with marked success.

REMARKS.

Case 1.—This patient had pus in the gall duct, and had, in fact, suppurative cholangitis in its early stages. That the suppuration had not extended into the minute ducts in the liver, was shown by the immediate and permanent fall of the temperature after the operation. If she had been allowed to go on a little longer the cholan-

gitis would have spread higher. The stone which had been passed *per anum* had clearly ulcerated into the duodenum, between which and the gall-bladder dense adhesions were found. It was a lucky thing that the stone had not got arrested in the lower end of the ileum. The stone was capable of being displaced backwards into the first part of the gall-duct above the duodenum. This is nearly always possible with some perseverance. It is important to try to do it, because the mortality of operations for the removal of the stone in the first part of the duct is much smaller than that of the operations that are in the second and third part of the common duct, as in all cases of common duct obstruction, and especially with the presence of suppuration in the duct. Drainage of the duct is absolutely essential both for saving life and for the restoration of the ducts into a healthy state. It is not at all necessary to put any sutures in the duct, but one catgut stitch passed through the peritoneal covering of the duct and a tube serves to keep the latter from slipping out. A very large tube passed into the right kidney-pouch serves to collect all the bile that leaks during the first day or two by the side of the tube. Later all the bile passes through the small tube fixed in the duct. It is important to keep the patient lying flat for the first day or two after the operation in order to prevent any leakage of bile out of the right kidney-pouch into the general peritoneal cavity. When adhesions have formed to prevent this, it is an advantage to put the patient in a semi-sitting position in order to prevent the development of pulmonary complications. The gall-bladder was, as is usual in these cases, very shrunken and fibroid.

Case 2.— This presented unusual difficulties on account of his extreme obesity and chronic bronchitis and the rigidity of his back, which discounted the effect of the gall-bladder cushion at the level of the back. Moreover, the gravity of his disease was greater because of the long duration of the obstruction and the situation of the stone below the union of the common bile duct and the pancreatic duct. Thus, obstruction of the pancreatic duct was added with secondary changes in the pancreas. Fortunately there was no glycosuria. An unusually large incision had to be made in order to gain access to the duct. The stone was so firmly embedded in the wall of the ampulla that it was impossible to press it back into the first part of the duct. The trans-duodenal route was preferred to the retro-duodenal, because in the latter the pancreas is, of necessity, wounded (a serious thing, from the gradual escape of the pancreatic juice into the peritoneal cavity); and the opening into the common duct is in an unfortunate position for drainage. The transverse duodenal route is a great deal safer than the retro-duodenal; but in some cases published a duodenal fistula has followed and has ended fatally, so that it is of great importance to take great care in sewing up the wound in the duodenum. The knots of the through-and-through suture should be placed inside the bowel, otherwise leakage is very likely to occur. It is easy to fix some of the transverse meso-colon up over the wound to reinforce the sero-muscular suture. To avoid narrowing the duodenum the wound in its anterior wall must not be made too long, and a longitudinal wound must be sewn in a transverse direction, as in pyloroplasty. It is necessary to clamp the common bile-duct with the pylorus in order to prevent the infective contents of the gall-bladder and the bile-duct escaping into the wound. To get the duodenum out into the abdominal wound, it is usually necessary, as in this case, to divide the parietal peritoneum about one inch to the right of the descending part of the duodenum. A little blunt dissection will then enable the surgeon to bring the duodenum and the stone into the wound. It is a common mistake to place the incision in the duodenum too high up. It should be as long as possible in the second part quite close to the root of the transverse meso-colon, for the papilla is placed lower than is generally supposed. The healthiness and distension of the gall-bladder in this case were unusual. In such a case, and when the cystic duct is patent, it is best to make use of the gall-bladder for drainage purposes. It is better than draining the common duct directly. In sewing the tube into the fundus of the gall-bladder, the edges of the wound in the latter are inverted to promote early closure of the fistula.

In the after-treatment of these cases, the large tube in the kidney-pouch is generally removed on the fourth day, and the smaller one usually comes away about the eighth day. The fistula closes about the twelfth day, and the wound heals completely by about the fourth or fifth week. To prevent hernia, the lower part of the wound is carefully sewn up, and only a small gap is left for the drainage. The large tube contains a wick of gauze.

The mortality of operation for stones in the common bile-duct has diminished very considerably in the last few years, chiefly on account of earlier operation, and partly as a result of improvements in technique.

The Bonfire.

IT is the last night of the old year. Our Christmas Week has neared its end, and soon will be gone in a blaze of revelry. For they are building the great fire before the gates again, the yearly burnt offering to the memory of Thomas Guy, as "in our wont of twice one hundred years, we've piled our faggots round his ancient fane."

The Bonfire! The Old Year!

The old year is going, and we fain would let it go. With the fierce joy of the wild vandal in our blood we are glad to see it go in chariots of fire.

And yet the old year was a happy year for the most of us. A jollier year we shall not see. Of course there have been many mistakes. Of course there have been some failures. Men have been "shot," as men will be "shot," for men, some men, must be "shot." It is all in the very nature of things.

But for the most of us the old year has been a happy year. And the end of the year is Christmas Week. And our Christmas Week was a great success. Everybody said so. It was the dominant note of every occasion. From the first throb of the big drum of those wonderfully jolly and unselfish Niggers, to the last wheeze of their horrid mouth organs, through all the several concerts in the gay and giddy wards, with every encore of the happy Gilbertian Sullivans, to that last merry outburst in Astley, the dominant note of every occasion was the note of success. Everybody heard it. Everybody felt it. Everybody said so. All the patients, all the nurses, all the sisters, all the "doctors," on and off the Staff, with all the vast armies of their sisters, and their cousins, and their aunts.

But the children's praises were the loudest. If you had visited "the back" on Christmas Day you would have known that the children's praises were the loudest. If you did not, ask "Sonny" Mann.

Oh! that happy Christmas Day! What a contrast to the dark squalor and the cramped misery of the Borough Home! What a flood of sunshine for the bright little flowers that are trying to grow among the old tins, and the broken bottles, and the dead cats, of England's neglected back garden! But why think of these things? For they needs must be—the old tins, and the broken bottles, and the dead cats, and the bright little wasted flowers. Why think of all these things—in Christmas Week? Why, indeed?

So the week was voted a great success, and to-night is its last. To-morrow—and the magic of Yule will be spent. To-morrow—and every sister is Sister, and every pro. is Nurse. To-night, this week, and not again for another year, has every nurse been but a sister, and every sister just a pro. again. Oh, the magic of Yule! the mystic magic of Yule!

The Astley Concert has just given over. It was the noisiest, the jolliest, the happiest concert of them all. The dainty blues and lilacs, all have gone. And the preparations for the bonfire have begun. For some of us, the last.

From all parts of the hospital grounds are heard the shouts that tell of treasures found or of some spoil of victory. Every now and then some exulting worker staggers along the Colonnade beneath the burden of his booty. Every now and then a hand-cart comes rushing down like a torrent in Spring, heavily laden with a marvellous collection of assorted brands for the burning. Old doors, discarded chairs, the legs of tables, "decorations" from the wards, the odds of boots, some odds and ends of wood, a big tea-tray and a pair of cracked enamelled jugs, a three-legged garden seat, a couple of rickety barrows, and an endless variety of other surprising articles that suddenly appear from nowhere. And then there was a large barrel of tar. And another barrel of oil—a very costly barrel of oil, that was found disconsolately cold and alone somewhere in the dim regions that appertain unto the Hospital Pharmacist. Oh, it was a good fire! And it did burn so beautifully. But the noise in the making! And the excitement thereof! There can be only one such night in all the year—the night when the entire Borough turns out to try and rush our barred and bolted gates in its vain struggles to get a peep at "the stoodents' amusements!"

And now the fire is full ablaze, and the long ring closes. Hand in hand the annual dance around the Idol and its sacrifice begins. Soon the High Priest of the ceremony advances toward the centre of the revolving circle, and enters into the very Holiest of Holies, standing on the plinth beside the great Guy himself, with the uplifted torch of office in his free right hand, as has been the custom from time unknown every year unto this very day.

And the circle circles faster, and ever faster. And lo! it grows in number. One, two, three, and more revolving circles now appear. One behind the other. One, two, three, and more, like the images between a pair of parallel mirrors. One, two, three, and more, back, back, back into the dim, dead, ever-living past. One, two, three, and more, on, on, on, into the unborn yet ever-present future. And the fires, too, are numberless, and the High Priests with the fires. But the Idol is one.

So the circles revolve. Each is each. And each is the other. And the all is all and in all. None can tell the substance from the shadow; none the reality from the unreal. So the circles revolve, mingling one with the other, and each with each. So we, the objects of the hour, blend with the mighty memories of the Past, and grow into the greater visions of the Future. Such, indeed, is this our glorious brotherhood of Guy's, for we, and they, and those to come, though many, are but one. And our bonfires are, in truth, the bond-fires of the years.

Again the circle changes. Wider it grows, and wider, ever wider, till it throws a girdle round the world. To-night, somewhere amid the frozen regions of the North, somewhere around the Southern snows, somewhere under a Western sky, somewhere beneath the glamour of the Eastern stars, somewhere upon a foam-flecked billow, somewhere within a lonely homestead, somewhere beside a silent kopje, somewhere anear a reedy jheel, Guy's men join hands with Guy's men within that ever-widening circle, and the old, old song goes ringing round the world, the dear old song of comrades and the days of auld lang syne, the old world-chaunt of fellowship around the bond-fire of the year.

And now the hour of midnight is come. The sad, sweet, mysterious hour of midnight. And, as the clanging gongs in the distance peal out the change in a very frenzy of endeavour against the loud hooting of the sirens on the river, the High Priest is carried, once, shoulder-high, around the circle by the other brethren, the holy brethren, the Residents of the year. And then the circle breaks, and all its members gather round their President, their President no more—

"Gentlemen, in the name of Thomas Guy,
I wish you all a very Happy New Year.
"Gentlemen, three cheers for Thomas Guy."

Three cheers, indeed! age-long, world-wide.

31st December, 1909. SIMPLICITAS.

Surgery on the Stage.

THERE are signs that the dramatist is beginning to treat doctors seriously. That impossible old bore—the stage doctor of 19th century drama—was a worse libel than Diafoirus, and Purgon, and Dr. Caius, and it was fully time that he should be replaced by a type (if we must have types) nearer the truth. It was one of Ibsen's great services to the drama that he introduced into his plays flesh-and-blood doctors, who are, as Mr. Edward Dowden says, "with scarcely an exception, either wise or shrewd, or, in their own fashion, heroic."

Now your doctor, especially your surgeon, is a promising figure for drama, for he deals with matters of life and death, which are an essential part of serious drama. In the past, nevertheless, his part has usually been a small one—a grave subdued figure who enters with bowed head, and speaks his one line: "All is over!"

In a one-act play, called "The Knife," now being played at the Palace Theatre, however, Mr. Henry Arthur Jones has demonstrated the possibilities of the surgeon as a dramatic rôle. He has, in fact, given a surgical setting to the familiar triangular sex-problem of the stage. Suppose the wronged husband to be a distinguished surgeon, and let him learn the truth about his wife's infidelity just before he is to do an important operation on the very man who is her lover; such is the problem Mr. Jones has set before us.

It may be said at once that, in spite of the name of the play, and in spite of a note on the programme to the effect that "the medical accessories are supplied by" such and such a firm—the knife plays no conspicuous part on the stage. The scene is the ante-room in a West-end nursing home; we get a glimpse of the operating room—no more; the surgeon comes from the operation and washes his hands after discarding a slightly-soiled overall—that is all there is in the way of professional horrors, so that the most timid playgoer need not be scared by the title. But the operation, though it takes place off the stage, is the pivot about which the whole plot turns.

Archie Kingsford has for some time been the secret lover of Lady Ridgway, wife of his friend Sir Mark Ridgway, the great surgeon. One day he speaks to Sir Mark about certain symptoms he has noticed, and he is told that immediate operation, which may or may not be successful, is necessary. For one reason we should like the operation to have taken place on the stage. Then we might have obtained some clue on a point on which we confess ourselves curious. What is the matter with Archie Kingsford? It is a case for diagnosis. We are told that it is a matter of life and death, and that an operation is imperatively necessary. The patient has had some pain for a day or two; we are not told its situation, but must suppose it abdominal, as he seems to have full use of all his limbs and his head. We leave the problem to our readers' ingenuity. For ourselves, we cannot help wondering if, after all, Sir Mark may not have been

gulling them, and saying that an operation was immediately necessary, when it was really only a hernia or something equally tame. But to continue the plot:—

Archie Kingsford therefore goes to the nursing home to be operated on by his friend. He has gone out against orders to send off a telegram to Lady Ridgway, begging her to come and see him, as he may not survive the operation. When the curtain rises we find Kingsford asking the nurse to deliver a letter for him in case he should never recover He is dispirited, and has a premonition that the operation is going to prove fatal. Sir Mark pooh-poohs the idea and invites him to dinner with them four weeks hence. No, not with them, but with his wife, as he himself is about to set out for the Boer War. Lady Ridgway arrives in answer to the telegram, with the pretence of some inquiry for her husband. The lovers are alone for a few minutes. Kingsford is still pessimistic and says good-bye to her, giving her the letter to open in case of his death. Just as the letter is passing between them, Sir Mark enters and sees that something is wrong. He orders Kingsford away to get ready for the operation, and then demands to see the letter, which Lady Ridgway has hastily hidden in her muff. She protests it is nothing—a mere shopping list. Sir Mark is obdurate; if it is nothing there can be no harm in his seeing it. A sudden interruption occurs; the nurse enters to say that the anæsthetist has been waiting some time—a real touch from Nature, that! The interruption gives Lady Ridgway the opportunity of going over to the fire and destroying the letter. Kingsford enters in his dressing-gown, and with a word of farewell to Lady Ridgway, enters the operating room. Sir Mark's suspicions have been thoroughly aroused, but Lady Ridgway continues to lie about her relations with Kingsford, and to explain away the letter. Just as she is leaving, positive proof arrives, in the shape of a telegram which had been brought some time before for Archie Kingsford, and been accidentally overlooked. As the patient is under the anæsthetic, Sir Mark opens it for him. Lady Ridgway waits at the doorway in an agony of suspense; it is the telegram she sent in answer to Kingsford's. "Why do you wait?" asks Sir Mark. He opens the telegram and sees the whole truth like a flash of lightning. His friend, the man he is about to operate upon, has stolen his wife's love from him. It is a very dramatic situation. She implores mercy, but shows no contrition, for she loves the other man and not her husband. Sir Mark is thinking of the operation. Does his hand shake? Suppose it should shake just a little during the operation—might not anything happen? Lady Ridgway screams with terror that another surgeon must be found, lest he is not sure of himself. But Sir Mark spreads out his hand—it is steady. He will operate. He enters the theatre, and Lady Ridgway falls on her knees in a passionate outburst of prayer for her lover's life.

The stage is darkened to denote the time of the operation. Then Sir Mark re-enters. It has been one of the most successful operations he has ever done; the patient has a good chance. Lady Ridgway has a sudden admiration for her husband, but it is because he has saved her lover's life. Sir Mark now realises that his wife's love has been given to Kingsford. He says good-bye; he will go to South Africa to the war, and leave them to one another. And then the curtain falls.

Mr. Henry Arthur Jones has made a very strong and telling little play out of this plot, and it is scarcely necessary to say what a sincere and convincing piece of acting is Mr. Bourchier's as Sir Mark; Miss Violet Vanbrugh also, as Lady Ridgway, and Mr. Charles Bryant as Archie Kingsford, do full justice to their parts, and the nurse acts like a real nurse and not like a stage imitation.

Mr. Jones has concluded the play in a way which has latterly become popular with our dramatists: the wronged husband, who is the strong, "sympathetic" character of the piece, magnanimously retires and leaves the lovers to themselves—which is all very well as an ending, but not very convincing as a solution. We wish Mr. Jones would write a play on the same lines, but in which the patient dies, as we are led to suppose he might well do, apart from any shaking of the surgeon's hand. (Oh, the romance of that fatal tremor! It is invaluable to the novelist.) Then the dramatist would have a very puzzling situation to work out, but that would take him into three acts.

It is seldom our privilege to see a one-act play of such sound workmanship as "The Knife." Still rarer is it to see serious work seriously presented on the stage of a music-hall. The Palace is well worth a visit just now, if for nothing else but to see "The Knife," which is timed for appearance at 9.45 each evening.

Reviews, etc.

Books for review should be addressed to The Editor, Gazette Office, Guy's Hospital, S.E. Their price should in every case be stated.

Serums, Vaccines and Toxines: In Treatment and Diagnosis. By W. Cecil Bosanquet, M.A., M.D., F.R.C.P., and John W. H. Eyre, M.D., M.S., F.R.S. Edin. 2nd Edition. (Cassell & Co.) Price 7s. 6d.

This book is one of Messrs. Cassell's series of Modern Methods of Treatment. The first edition was published five years ago, so that a complete revision of the text has been necessitated in order to do justice to the very considerable advances which have been made in this subject since that time. Practically all the work which has been done in connection with vaccines and opsonins is new. The chapter on tuberculin is particularly valuable, and in this edition due attention is paid to the modern views on dosage, whereby the dangers in the old scheme of treatment have been practically banished. There is a very instructive paragraph on the uses and limitations of tuberculin in treatment.

The amount of new material added has necessitated the omission of much of the introductory matter in order to keep the volume at its old size. The number of text-books on vaccine and serum treatment is rapidly growing, but the book before us remains the most complete and authoritative in proportion to its size, and may be confidently recommended to those up-to-date practitioners who desire information on these modern methods of treatment.

Sport.

Rugby Football.

GUY'S v. CATFORD BRIDGE.

The second half of the Rugby season began last Saturday with this return fixture, on the Catford ground. For numerous reasons, too varied to detail, Guy's had to include several men who are not regularly in the 1st XV. To some of these only the shortest notice that their services were required could be given, and special thanks are due to these players, who sportingly and promptly responded to the call. A glance through the team will show to some extent who these men were.

It was some time before the Guy's pack settled down, and during this period they had to submit to some bit of hustling from the pack opposed to them. Catford invariably rely on forward play, and the match under notice was no exception. When up to the Guy's twenty-five line they started heeling, and from several scrums they had opportunities which were not accepted. Guy's were driven back by "free-kicks" awarded with monotonous frequency, but at length got away to midfield; a bout of passing by Catford lost ground for them again, and a very wide pass to Brown on their left wing enabled that player to get past Stokes and score in the corner. Helder could not convert from the distance. But before half-time another "free" to Catford in Guy's twenty-five for "foot-up," gave Helder a chance of landing a goal, which he made good use of.

After half-time Guy's got the ball more often. The forwards got more together, and play generally was on a much higher level. Stranach was almost over the line, while Stringer did his utmost, when opportunity was given him, to pierce the defence. The Catford tackling was sound, and it was left to Stringer, who found the, way barred for a run, to drop an excellent goal. Laceyd at back, was putting in some runs, but his passing, or shall we say "holding on," was not well judged. Roe and Harkness were also too prone to leave the wing men in the cold, with the result that their opportunities were extremely limited. Before long Roe raced over on his own and scored a good try, which was followed by a good conversion on the part of Stokes. Guy's had a shock towards the end. The Catford front rank, led by Wilkins and Larmour, were badly "let away" by Stokes, an only great work by Lacey, ably aided by Harkness, who cleared to half-way, avoided a try. Medlock and Roe got Stokes away nicely on the right, but he was pushed into touch, and with play settled in midfield the game ended, with Guy's leading by 2 goals (1 dropped) to 1 penalty goal and 1 try (9 points to 6). Team:—

GUY'S.—G. E. W. Lacey (back); L. B. Stringer, A. H. Harkness, A. S. Roe, A. L. Stokes (three-quarters); C. B. Pritchard, C. H. Medlock (halves); H. R. Mullins, H. Hoby, W. S. Stranack, R. S. Kennedy, V. Glendining, H. Sharpe, T. D. Stout, C. B. Cockrem (forwards).

REMARKS.—Considering the forwards consisted almost entirely of men unknown to each other's methods, they did remarkably well. During the first half they were run about too much by long kicks failing to find touch. With Pritchard and Medlock no fault can be found. Stringer and Stokes were not made full use of; the latter might follow up his high punts more speedily, especially when the ball is greasy and liable to be misfielded. Both Roe and Harkness held on too long, and frequently made for the thick of the opposition when a pass would have been more serviceable. Lacey, also, forgot to part with the ball, and most of his excellent runs ended in Lacey and ball being buried beneath several opponents.

Appointment.

Territorial Force.

Royal Army Medical Corps. 5th London Field Ambulance. Captain ERNEST B. DOWSETT to be Major. Dated 22nd December, 1909.

From the Gazette's Special Pathologist.

ALL specimens—particularly those of solid tissues—should be accompanied, if possible, by a short clinical and post-mortem history, and a postal order for 2s. 6d. An extra charge of 6d. per slide is made when prepared sections are to be forwarded.

Directions to be followed in sending *Diphtheritic Membrane*:—Remove as much of the membranous exudation as possible with a pair of forceps, which have been sterilized by boiling water. Place the exudation in a small, perfectly clean empty bottle, with a well-fitting glass stopper, and forward without delay. No preservative fluid should be used. The specimen must be accompanied by a Postal Order for 5s. A telegram will be despatched immediately the examination of the specimen is completed.

Diphtheria specimens are to be labelled *Immediate*.

Specimens, Letters, and Postal Orders should be addressed to the MANAGER, Gazette Office, Guy's Hospital.

Ed.—A. N. C.

GUY'S HOSPITAL GAZETTE.

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Calendar of Coming Events and Ensuing Take-in Weeks.

January.

Sat. 22. 1st XV. v. Old Merchant Taylors (Away).
2nd XV. v. H. K. & S. Bank (Away).
1st XI. v. Wanderers (Away).
2nd XI. v. St. Bartholomew's "A" (Away).

Mon. 24. Clinical Lecture by Mr. Targett (Gynæcology), 1.15 p.m.
Physiological Society meeting, 4 p.m.

Wed. 26. 1st XV. v. Oxford University (Away).

Thur. 27. Messrs. Symonds and Steward's Take-in (Messrs. Crook and Mills).

Fri. 28. Guy's London University Club: Annual Dinner, Trocadero Restaurant, 7.30 p.m.

Sat. 29. 1st XV. v. London Scottish (Home).
2nd XV. v. African Banks (Away).
1st XI. v. Carshalton (Away).
2nd XI. v. Wanderers "A" (Away).

Mon. 31. Clinical Lecture by Mr. Eason (Ophthalmology), 1.15 p.m.

February.

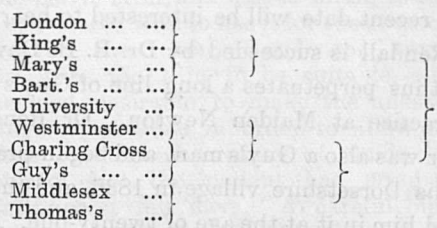
Wed. 2. 1st XI. v. Casuals (Home).
2nd XI. v. Brentwood School (Away).

Thur. 3. Messrs. Lane and Fagge's Take-in (Messrs. Mullins and Fitzmaurice).

Passim.

ONCE more the Gold Medal in the London M.D. Examination has been won by a Guy's man. We have pleasure in congratulating Mr. H. I. Janmahomed on his attainment of this coveted distinction.

THE draw for the Inter-Hospital Rugby Cup Ties is as follows:—



So that we have to win three matches before qualifying for the final. The first match in the series will be played before the end of the month.

THE sale of "Guy's" Christmas Greeting Cards, supplied gratuitously by Messrs. Ash & Co., Ltd., has this year provided a sum of £23 3s. 3d., which will be wholly handed over as a contribution to the General Funds of the Hospital. Besides affording all at the Hospital an opportunity of purchasing really excellent photographs of various parts of the Institution in this pleasant form, the presentation of these cards every year is also a means of contributing a useful gift to the financial requirements of Guy's. Thanks are due also to the Librarian and Miss Smith,

with others, who have rendered help in the sale of the cards.

WE are asked to announce that the Fifteenth Annual Dinner of the Dental Society will be held on Saturday, February 12th, at the Trocadero Restaurant. The dinner will be marked by an interesting innovation. The long and, to some of us, tedious list of speeches will be dropped, and, to take its place, two or three professional entertainers will be engaged. This should appeal greatly to both past and present students, and it is hoped that their appreciation will make itself apparent by a greater number of them attending the dinner than has been the case during the past years. Applications for tickets (price 6s. 6d.) should be made to the Hon. Secretary, Mr. S. Wilson Charles.

OLD Guy's men who were at the hospital in the seventies will be interested to hear that Dr. William Rendall, on leaving Maiden Newton in Dorset, where he has practised for nearly forty years, received a presentation from his friends and patients in the district. Guy's men of more recent date will be interested to hear that Dr. Rendall is succeeded by Dr. R. B. Dawson, who thus perpetuates a long line of Guy's men in practice at Maiden Newton. Dr. Rendall's father was also a Guy's man, and began practice at this Dorsetshire village in 1836, and the son joined him in it at the age of twenty-one. From that time up to the end of last year he has carried on the work of this hard country district, with public appointments, and has never had to seek the services of a *locum tenens* on account of ill-health—surely a striking testimony to the healthfulness of a rural practice. In his retirement, we learn from the *Dorset County Chronicle*, Dr. Rendall is not giving up country life, but is moving to Hempton Lodge, Stamford, near Hythe —"a beautiful home farm of considerable acreage, with excellent stock, electric light, and other up-to-date appointments." With "all his old friends," we "wish him the best of luck in his new undertaking, and every happiness in his new home."

The Physical Society.

A Clinical Meeting was held in the Library on Wednesday last, January 19th, Mr. C. M. Plumptre in the chair. The following cases were shown and discussed:—

Cerebral Tumour. Mr. Attwater.
Infantilism (? Cretin). Mr. Jones.
Congenital Coloboma of Iris and Choroid. Mr. Neville Cox.
Bulbar Paralysis. Mr. Hart.
Sclerodermia. Mr. Francis.
Tabes, with Aortic Disease and Paroxysmal Hæmoglobinuria. Mr. Parmiter.
1. Sarcoma of Superior Maxilla. 2. Thyroid Tumour. Mr. James.
Tabes. Mr. Gatley.

The following members took part in the discussion, in addition to the President and Hon. Secretary:—Drs. Mann and Goodhart, Messrs. Layton, Lee, Sharpe, James, and Neville Cox.

Guy's Physiological Society.

AT a meeting of this Society on Monday, January 10th, a paper was read by Mr. C. Sherris, entitled: "Hearing." Mr. Hughes took the chair.

The paper dealt with the subject from two points of view, namely, the means by which waves of sound are conducted to the internal ear, and the theories put forward at various times to account for the method of taking up sounds by the modified auditory epithelium. In considering successively the external, middle and the internal ear, it dealt with their functions as regards conduction and protection. It explained, also, the method by which the tympanic membrane vibrated, and the mechanical arrangement by means of which the amplitude of the vibrations of that membrane was diminished, but the force correspondingly increased, thus ensuring the stimulation of the cochlea even for very soft tones. (The method of stimulation of the muscles of the middle ear and their functions were touched upon, and experiments were quoted to illustrate these functions.)

Localisation of sound was dealt with briefly, and a general account of the structure of the cochlea was given. Upon this followed the consideration of the various theories. Schäfer's "Artificial Cochlea" experiment was described in detail, and was considered to be very strongly in favour of the Helmholtz theory. The theories of Rutherford, Waller, Hurst, and Max Meyer were briefly discussed.

In conclusion, it was pointed out that, although analysis takes place in the end organ, yet the ultimate fusion takes place in the brain, and until the action of that organ is understood, hearing cannot be explained satisfactorily.

In Clinical.

BY R. P. ROWLANDS, M.S.

A lady, aged 47, came in suffering from acute intestinal obstruction and frequent vomiting. The obstruction had been complete for four days. She gave the history of having had an operation in the Obstetric ward about Christmas, 1907. In the report it was stated that a simple ovarian cyst had been removed. On admission into Clinical there was a hard mass at the upper end of the abdominal scar, near the umbilicus. The mass extended towards the left, and was as big as an orange. The obstruction seemed to be in the small intestine, for the flanks were not full, nor was the abdomen sufficiently distended for a growth of the sigmoid. No abnormality could be discovered upon pelvic examination. The abdomen was opened to the right of the median scar and below the growth. It was then discovered that the carcinoma had invaded the small intestine about two feet from its termination in the cæcum. It was decided to resect the portion of intestine involved and the abdominal growth in one piece, including the skin. An incision was made through the skin around the growth, and the remainder of the parietes was divided with scissors guided by the fingers of the left hand placed within the abdomen and protecting the bowel. The large mass was withdrawn and packed off from the abdominal cavity. The mesentery was tied, and stout silk ligatures were firmly tied round the bowel, twelve inches above and two below the growth. The ligatured ends were then inverted by means of purse-string sutures, reinforced by a few Lembert turns. A lateral anastomosis was then made between the ileum and the middle of the sigmoid colon. No secondary growths were discovered in the liver, but there was a flat plaque in the floor of the pelvis on the posterior wall of the bladder. This was not removable. The abdomen was closed in layers. The patient seemed to be doing very well for three weeks after the operation, but then she began to lose flesh rapidly, and died a week later. At the post-mortem examination a small pelvic abscess was discovered which had been unsuspected during life. The temperature had not been raised, but the pulse had become quick towards the end.

In this case the choice lay between (1) an artificial anus in the ileum, (2) a short circuit between the ileum above the obstruction and the sigmoid, and (3) resection together with an anastomosis. I had no hesitation in choosing the latter, because the growth could be resected very rapidly by the method described, and the chance of greater prolongation of life seemed to be worth taking. An artificial anus in the small intestine is such a troublesome and dangerous thing that it should always be avoided if possible. Life is hardly worth living with such a condition, involving a great loss of fluid and constant irritation of the skin of the abdomen. Moreover, a secondary major operation becomes necessary in order to close the fistula in the majority of cases. With careful suturing I find that leakage from an anastomosis well made, even in the presence of acute obstruction, is very rare. If there be any slight increase of risk of death, it is surely worth the patient's while to run it in order to be able to avoid a fistula in the small intestine and the need of a secondary operation to close this. I believe that in these cases a lateral anastomosis is far safer than an end-to-end union, because the risk of leakage is less, and the drainage more efficient, since the artificial opening can be made as large as desirable. In this case the small stump of ileum left was so bound down to the pelvic brim, and was so small, that it was not considered wise to use it for the anastomosis. Moreover, the cæcum and the transverse colon were too thin to be suitable, although it seemed desirable to make the anastomosis as high as possible in order to allow a large surface for the absorption of fluids. As a matter of fact, the patient had no diarrhœa after the first few days. A careful bimanual examination when the patient's general condition got worse would probably have revealed the presence of the small pelvic abscess, and the drainage of this would have prolonged life. It is open to question whether it would have been wise to drain the pelvis for a day or two after the operation, seeing that the anastomosis had to be made late in acute intestinal obstruction. But I hardly believe that this would have prevented the formation of the pelvic abscess, which probably did not develop until a long time after the operation. In making the anastomosis in these cases of complete obstruction it is particularly important to prevent contamination of the abdominal wall and of the peritoneum by carefully protecting these with gauze packs before the bowel is opened.

Guy's Hospital.

Some Statistics.

January 1st, 1910.

In accordance with annual custom the House-Committee publishes, for the information of the Medical, Surgical, and Nursing Staff, the following tables showing the total number of patients sent during the past year to the various Convalescent Homes connected with the Hospital, and the amounts found in the Ward Collecting Boxes, together with special donations:—

Wards.	Number of Patients. 1909.	1908.
Astley Cooper	12	23
Cornelius	22	23
Lazarus	36	21
Job	47	52
Naaman	30	10
Luke	37	32
Patience and Samaritan ...	36	32
Charity	46	50
Dorcas	27	23
Lydia	48	56
Martha	31	29
Eye Wards	21	19
Addison	62	103
Mary	75	62
Stephen	52	44
Esther	82	84
Queen Victoria	50	47
Clinical	63	76
Isolation	—	1
Surgery	—	1
Out-Patients	34	52
	811	840

The subjoined list gives the distribution of the patients amongst the various Convalescent Homes:—

Ascot Priory	146
Barnet (Children's Hospital)	7
Bexhill (M.C.I.)	16
Bognor (Merchant Taylors)	16
Bognor (Surrey Home)	3
Bournemouth (R.N.S.C.)	1
Brighton (St. Oswald's)	2
Broadstairs (M.C.I.)	85
Broadstairs (St. Mary's)	2
Gringley (Col. Laycock's Home)	39
Margate (R.S.B.H.)	1
Rustington	16
Seaford (Surrey Home)	1
Swanley	284
Walton-on-Thames (M.C.I.)	55
Worthing (Miss Henry)	137
	811

List of amounts received from patients in the various wards, and sums found in Ward Collecting Boxes, etc., for the year ending December 31st, 1909. The amounts received in the previous year are inserted for the purpose of comparison.

	Box Collections 1909. £ s. d.	Special Donations 1909. £ s. d.	Totals for 1908. £ s. d.
Counting House ...	24 7 10	—	19 0 6
Office of Secretary to Treasurer ...	2 8 9	—	1 3 9
Front Gate Box ...	7 10 4	—	2 9 4
Porter's Lodge ...	20 11 10	—	18 5 5
Out-Patient Dept.	21 19 4	—	113 0 2
Surgery	6 14 3	4 0 0	8 1 7
Conservation Room	4 3 0	—	2 0 10
Actinotherapeutic Dept.	2 8 9	5 0 0	6 1 7
Massage Dept. ...	0 5 1	—	0 4 0
WARDS—			
Addison	0 18 5	1 0 0	6 10 10
Astley Cooper ...	3 4 3	27 2 6	3 6 5
Bright	3 0 9	3 3 0	9 0 11
Charity	0 14 8	3 2 0	19 7 9
Clinical	2 16 0	15 5 0	7 18 3
Cornelius	2 6 4	9 3 0	23 5 8
Dorcas	2 11 10	40 4 0	69 16 3
Esther	4 6 0	5 0 0	1 15 4
Eye	4 19 10	14 2 0	10 3 5
Job	5 9 0	24 19 0	19 14 0
Lazarus	4 11 3	40 5 0	25 2 2
Luke	5 10 4	13 13 0	13 19 0
Lydia	5 6 0	4 5 6	5 3 6
Martha	3 6 10	33 0 6	22 16 11
Naaman	6 6 9	66 13 0	21 2 1
Mary	4 10 2	18 11 0	11 11 8
Patience	0 14 8	6 16 0	10 8 1
Queen	8 8 11	61 6 6	32 10 1
Victoria	—	—	12 9 7
Stephen	1 16 0	14 4 0	1 19 2
	£161 7 2	410 15 0	498 7 9
	Total		£572 2 2

Papers by Guy's Men.

Kenelm H. Digby, M.B., B.S. Lond.: Displacements of the Semilunar Cartilages (Illustrated).—*The Lancet*, 15th January, 1910.

Dudley Kennard, F.R.C.S.: Lime Water in the Treatment of Verruca Plana.—*British Medical Journal*, 8th January, 1910.

A. Kinsey-Morgan, M.D. Durh., M.R.C.P. Edin.; Beschreibungen von Bädern: Bournemouth.—*Zeitschrift für Balneologie*, December 15th, 1909.

W. Arbuthnot Lane, M.S. Lond., F.R.C.S.: Intestinal Stasis.—*Clinical Journal*, January 19th, 1910.

Guy's Hospital Debating Society.

A MEETING of the Debating Society was held in the College Smoking Room on Saturday, January 15th. Mr. Ormond occupied the chair.

Mr. NEVILLE COX moved—"That in the opinion of this House it is the duty of every medical man to prolong life." Prefacing his remarks with expressions of relief at being able, for the time, to set aside all thoughts of politics and to enter instead upon a purely ethical discussion, he continued to the effect that he had always considered the principles embodied in the motion in the light of an axiom, and for this reason was surprised that anyone should attempt to disprove them. He first pointed out that the student, on leaving the laboratories for the wards, was frequently under the impression that the world could be ordered entirely on Darwinian and scientific lines; his later experiences necessitated an alteration in these ideas. He supposed that his opponent would argue that it was in some cases the doctor's duty to assist a patient to die. To whom was such a duty due? Was it to the State? He emphasised the fact that doctors were not yet State servants, and that their sole duty was to their patients as individuals. Serious consequences would probably result, and the medical profession would naturally be regarded with suspicion if such ideas as these became legalized realities. From the patient's point of view it should be remembered that there was always the possibility of a wrong diagnosis, for medical men were not infallible. From the ethical point of view he considered that the doctor should be always hopeful, and so capable of inspiring hope in his patients. Under no circumstances was the violation of the precept, "Thou shalt not kill," justifiable.

Mr. H. GARDINER in opposing the motion, declared that the hon. proposer had been working too much on suppositions of the type of arguments his opponents would employ. Preconceived notions were always inclined to lead one astray. He admitted doctors were not State servants, but maintained that every citizen had a duty towards the State, and medical men a very special one. His duty was not to be determined by civil law, but by moral obligations. The hon. proposer was setting a very low standard for the members of the profession in urging that abuses would become rife were such moral obligations more generally recognised. He suggested that the question of life or death in such cases as they were discussing should be settled by the individual, not by the law. The hon. proposer had said that morphia could always be used for relief of great pain; did not morphia frequently have the effect of hastening death? In a large number of cases the diagnosis was correct. He reminded his audience that the medical man had two chief duties: (1) to the State, (2) to the individual; it was essential that he should not help the unfit to survive. The proposer seemed to be of the opinion that the doctrine of "the survival of the fittest" did not apply to mankind as it did to animals. Would it not be much better if it did? As regards the individual, it was true that the doctor must endeavour to improve the patient's fitness; where it is not possible to enable a man to lead a useful life, is it not the doctor's duty to the State to allow that man to die, if every effort is being made to relieve his suffering? The doctor's function was more to prevent disease and suffering than to prolong life. If in preventing suffering he hastened death, he had not failed in his action.

Mr. E. G. SCHLESINGER, who at a moment's notice undertook to second the motion, said he stood aghast at the proposals set forth by the honourable opposer. He admitted that the doctor's function was to combat disease, but how, he asked, could he do so without prolonging life? Nature would always see that a patient had not more pain than he could bear with the help of drugs. He wished Darwin could be present to contradict the frequent misinterpretations of his doctrines. He urged that it was not the physically fit we wanted to survive, but the mentally fit. Surely it was illogical to argue that doctors were not to perform those very duties which they were trained and educated to perform. Treatment should always be active, and active to the very last.

Mr. LEVINSON, who seconded the opposition, declared that human nature and the laws of decency alone should be sufficient to determine us as to whether it was right to prolong the life of a person suffering from a painful and inoperable disease. He quoted one eminent surgeon as having said that the best course for a patient suffering from carcinoma of the intestine was to commit suicide, and another to the effect that an operation in a case of epithelioma of the palate was unjustifiable. Again, was it right to prolong the life of an infant born with syphilis? Was it fair to the child or to the race as a whole? He deplored the attitude of the proposer, who, he presumed, would say "never mind racial degeneration, keep the child alive."

Mr. BENTLEY considered that it was quite possible to take a middle course, by assuming a passive attitude in cases in which indecision arose as to the right mode of action. In certain cases, however, such as the birth of a monster, it did seem really wrong that the doctor should endeavour to preserve life. With regard to the statement made by the seconder of the proposition to the effect that Nature was considerate to sufferers, civilization and its consequences had, he said, been left out of account. He maintained that an operation in serious cases should not be employed unless there was a certainty of ultimate good resulting.

Mr. J. A. RYLE opposed the motion on the grounds that, in so far as the aim of human existence (just as of most human religions) seemed to be the attainment of the greatest happiness and good, it was unjustifiable for the medical man to prolong the sufferings of a patient afflicted with an incurable disease. In doing so he was, in fact, sustaining a pathological condition in the organism of humanity. Would it not be much

better both for the surrounding tissues and for the whole if he were to eradicate that pathological unit?

Mr. W. W. COOK urged that we were not justified, even when the patient presented an inoperable case, in putting an end to him. In a case of murder and attempted suicide, for instance, our sole duties were those of medical men, and we should do our best to save the murderer, whatever his ultimate fate was to be. The existence of pathological conditions was essential for the study of medicine. He gave several instances of patients who had lived, in spite of having been given up as hopeless by their doctors.

Mr. NEFT pointed out that if the doctor was not to prolong life, it did not necessarily follow that he was to kill. Neglect was frequently the best way of saving life. He quite agreed that useless lives should not be saved; the opposition were not proposing wholesale administration of fatal doses. By life we should understand life worth living

Mr. BERRY considered that we were not justified in doing away with things we were incapable of creating.

Mr. CRUMP pointed out that doctors were called in by sufferers not to kill, but to cure; but he admitted that there were a few cases in which the prolongation of a life was unjustifiable.

Mr. GODDING thought that the training and education he was receiving was intended to fit him for prolonging lives. If the principles upheld by the opposition were to come into practice, mistrust of the medical profession would be bred in the minds of the laity.

Mr. ECCLES considered the one justifiable occasion for shortening life to be in the case of a malformed infant at birth.

Mr. ORMOND, who temporarily vacated the chair, spoke in support of the motion, but gave one instance of a patient suffering from a severe aortic aneurism in which the accompanying pain was so terrible that it was at length deemed advisable to administer an overdose of morphia. Such cases were fortunately rare. He maintained that the medical man ought never to read into the patient his knowledge of the patient's sufferings. Further, he advocated not destruction of undesirables, but a system of race breeding which would tend to diminish their production.

Mr. BROWN agreed that we should take steps towards the breeding of a healthier race.

Mr. GARDINER, in reply, argued that an individual who, though alive, was of no use to himself, his friends, or to society, was much better out of his misery. The survival of the fittest was the most human principle. He did not agree with the seconder of the proposition in that it was the mentally fit, not the physically fit, who should survive. In answer to a statement of Mr. Cook's, he said that the whole aim of medicine was the removal of pathological conditions.

Mr. NEVILLE COX, declared that his opponents, although attacking his position, had failed to state what the duty of the medical man was. They had limited their cases to the vanishing point. He considered the suggestion of "a passive attitude" deplorable, and sincerely hoped that the views held by the hon. proposer would never become widespread.

The motion was then put to the vote and carried by 8 votes to 6.

The meeting closed with a vote of thanks to Mr. Ormond for occupying the chair.

Appointments.

Medical School Appointments.

The following appointments have been made by the Treasurer upon the recommendation of the Medical Council:—

Clinical Assistants in Medical Wards.—Messrs. W. S. Kidd (Dr. Hale White); N. L. M. Reader (Dr. Pitt); C. C. Tudge (Sir Cooper Perry); J. Pryce-Davies (Dr. Shaw).

Clinical Assistants in Surgical Wards.—Messrs. H. Shaheen (Mr. Symonds); F. D. Saner (Mr. Dunn).

Ophthalmic Dressers.—Messrs. B. T. Verver, G. E. W. Lacey (Mr. Eason); E. P. Poulton, A. Stanley Roe (Mr. Ormond) (February 1st); G. Maxted, T. D. M. Stout (Mr. Eason); G. Dunderdale, C. Witts (Mr. Ormond) (March 16th).

Surgeons' Dressers.—Messrs. H. L. James, H. H. Davis, N. Mutch, A. J. McNair, A. H. Todd, H. L. S. Griffiths (Mr. Symonds); A. C. Jepson, R. Heaton, H. Daw, M. C. Wall, G. L. Preston (Mr. Lane); H. P. Warner, G. Marshall, F. G. Lloyd, N. S. Carruthers, A. Seabrooke, A. H. Birks (Mr. Dunn); O. E. Williams, P. J. Monaghan, A. J. Frädersdorff, G. W. M. Andrew, J. B. Hance (Sir Alfred Fripp).

Externs.—F. A. Dick, E. Billing, T. Lewis Jones, M. C. Thavara, G. R. Hind (February); A. L. Gardner, E. A. Penny, T. S. Sharpley, R. Stout, G. C. Lowe (March); H. F. Renton, C. D. Killpack, B. Blackwood, J. A. Delmege, W. P. Vicary (April).

Papers by Guy's Men.

John D. Malcolm, F.R.C.S.: Cholecyst-duodenostomy for Acute Emaciation following the formation of a Biliary Fistula.—*Clinical Journal*, January.

N. Ivens Spriggs, M.D., B.S. Lond., F.R.C.S. Eng.: Some Cases of Intestinal Obstruction.—*The Lancet*, January 8th, 1910.

H. W. Webber, M.D., M.S. Lond., F.R.C.S. (and another): Ectopic Fœtation; Laparotomy; Diffuse Peritonitis: Recovery.—*British Medical Journal*, 8th January, 1910.

PERIODICALS RECEIVED.—Hospital; Clinical Journal; St. Bartholomew's Hospital Journal; The Nursing Times; South African Medical Record; Prescriber; Polyclinic; Stethoscope; Manchester University Magazine; St. Thomas's Hospital Gazette; St. Mary's Hospital Gazette; London Hospital Gazette; St. George's Hospital Gazette; Manchester Medical Students' Gazette.

Tetanus.

CLINICAL LECTURE.

BY GEORGE NEWTON PITT, M.A., M.D.

GENTLEMEN,—It so happens that during the past fortnight we have had four cases bearing on the question of tetanus in the wards, and it will be interesting to discuss these cases and also to review some general aspects of the disease. Mr. H. Steinbach has kindly prepared an abstract, which is appended below, of the forty-five cases which have been admitted into the hospital during the past twenty years.

The first of the recent cases was that of a bricklayer, aged 48, who was admitted on October 9th with the following history: On September 20th he trod on a rusty nail, and wounded the left great toe. The wound was treated with fomentations, and apparently healed up. Three days previous to admission he complained of a stiff neck, with aching, and difficulty in swallowing. The stiffness increased, the muscles of the back became involved, and upon admission he had also rigidity of the chest, so that it was difficult for him to cough. His abdomen was as hard as a board. His appearance was that of great suffering; he had considerable pain in the back, and well-marked trismus—indeed, he could hardly separate his jaws at all. The muscles of the neck were stiff, and any movement of the head caused pain. He also had a risus sardonicus. The angles of his mouth were depressed and his forehead was wrinkled. He had an extensor plantar reflex. We decided that the best thing to do was to amputate the toe at once, and to inject 20 c.c. of anti-tetanus serum into the spinal canal, and a further 20 c.c. intravenously, 15 c.c. of cerebro-spinal fluid being first drawn off. No tetanus bacilli in the cerebro-spinal fluid. He had two injections of morphine, gr. $\frac{1}{4}$, on the night of admission, and 20 grains of chloral per rectum. On the following day, when he had severe spasms, three injections of $\frac{1}{4}$ grain of morphine were given. Twenty c.c. of the anti-tetanus serum were again injected into the spinal canal, and a similar quantity into the vein. He also inhaled oxygen constantly, and had a continuous rectal saline. He was in a condition of opisthotonus. On the next day he had convulsions, and his respiration was extremely bad, 20 c.c. serum were injected at noon into the vein, but at 2 a.m. the breathing stopped and the pulse could not be felt. Artificial respiration was resorted to, and 20 minims of ether were injected into the heart. There was a revival of function, but the former state returned, and the patient expired about five o'clock. A point worthy of attention in this case is that the symptoms did not begin until rather late—nineteen days after the original injury—and when this is so, there is generally a fair chance of saving the patient. Having once started, however, the symptoms developed very rapidly, and he died within two days of admission, without showing any benefit from the serum.

Only two days later, on October 13th, a woman, aged 43, was admitted. She had been out hop-picking, and had bruised and abraded a corn on the metatarso-phalangeal joint of the great toe with a rough boot on October 9th. At 11 a.m. on the 13th there was stiffness in the neck; it was more definite by 2 p.m., and the jaw was slightly stiff, and still more marked at 5 p.m. She was admitted to the hospital at 7 p.m. with marked trismus, but no pain. (The preceding case complained greatly of pain.) Indeed, this patient felt very well, except that she could not open her mouth, which remained tightly clenched throughout. There was occasional contraction of the facial muscles. There was no tenderness in the back and no rigidity. Flexor plantar reflex. Her breathing was quite natural, but she had some difficulty in swallowing. The mouth was in a very foul condition. At midnight we removed the great toe, 20 c.c. of serum were injected into the spinal canal, and also 20 c.c. into the vein. The patient had incontinence of urine throughout. She was fed with nutrient enemata, and had injections of morphine from time to time. On the following day 40 c.c. of serum were put into the vein, but none into the spinal canal, as her condition of severe spasm seemed to contraindicate any disturbance. On October 15th she had four series of convulsive attacks relieved by chloroform. An attempt to feed her with the nasal tube

brought on severe laryngeal spasms, and her condition was extremely critical. Cyanosis began to develop, and respiration became more and more laboured on account of the fixation of the chest. Towards the afternoon her condition was so grave that artificial respiration had to be resorted to, and twenty minims of ether were injected into the heart. There was a rally, but the condition re-appeared, and artificial respiration was again employed at 2 p.m. and again at 11 p.m., on account of cessation of respiration and failure of the pulse. She revived and slept quietly during the afternoon. On October 16th ether or chloroform frequently administered when spasms were severe. Six injections of morphine were made in the course of the day, in order to control the spasms. She gradually got worse, and the rigidity became more extreme, but she was sensible to the last. Respiration finally ceased in the evening. Tetanus bacilli were cultivated from the wound on the toe. In both these patients death occurred through respiratory failure from fixation of the chest.

On October 20th a schoolboy was admitted with the following history. It was thought that this also was a case of tetanus, but he died one hour after admission. Two weeks previously he had sprained his back. He said nothing about it to his parents, and regarded it as a slight affair. Three days before admission he had had some muscular twitching. These were more marked next day, and his back became stiff. There was a little doubt as to when trismus commenced. The boy had cut his right wrist slightly three weeks previously, but this had soon healed. On admission his pulse was 140, and respiration 42. His face was pale and covered with sweat. He had spasms of the trunk and extremities every three or four minutes. He did not complain much of pain save in his legs, but he had tenderness over the spine. His abdomen was rigid, and the movement of the jaw limited. A lumbar puncture was made, when the boy passed into a state of opisthotonus, his breathing became shallow and stopped before any cerebrospinal fluid could be drawn off. Oxygen and artificial respiration were tried, but he did not improve, and after one and a half minutes his heart ceased beating. The question was whether this was a case of meningitis or tetanus. The clinical evidence pointed rather to the latter, but post-mortem a cultivation of a meningo-coccus was obtained from the cerebrospinal fluid, which showed that it was really a case of meningitis. I might add that the tetanus bacilli were cultivated from the wound in the woman, but not in the other cases.

As a contrast to the above, I may refer to another case of a man, aged 24, who was admitted on October 16th with inability to open his jaws. Five days previously he had noticed that his jaws were fixed, and could not be opened much more than half an inch. There was no spasm, and no evidence of any illness. On examining him it was quite clear that there was some swelling of the connective tissue around the jaw on the right side, but it was not certainly demonstrable then whether this was due to an inflammatory condition behind the pharynx or to an impacted molar. Twenty-four hours later, however, it was clearly shown to be due to the latter. The molar was removed, and the condition gradually quietened down. Although there is still some suppuration around the cavity, there is no doubt that the man will shortly be well.

I wish now to say a few words generally with regard to these conditions. Cases of tetanus are not very frequent. We have had 45 cases during the last 20 years. As a rule, the disease is found about six times more frequent in men than in women, owing to the fact that men are more exposed to traumatic influences. The disease is particularly common in cold and wet weather. Whether the very bad weather we have been having lately is responsible for these cases within a week, I should not like to say. Sometimes there have been regular epidemics of tetanus. At St. Kilda some years ago it was found that two-thirds of the children born died from this disease, which became known as the eight-day island sickness. This heavy mortality was ultimately entirely prevented by sending over trained nurses with instructions to use a clean dressing for the umbilical cord of the infants, instead of the

dirty piece of carpet which it had been customary to use in the island. The same thing has occurred in the West Indies.

Not until about 1876 was it realised that tetanus was an infective process, and in 1884 Nicolaier discovered the bacillus in earth, and set up tetanus by inoculations. The bacilli, which are very commonly found in earth or in manure, form spores, which will only develop under certain conditions. If there is plenty of oxygen it will not develop, the organism being anærobic. The virulence of the organism varies enormously, and is greatly increased in impure cultures. Agar cultivations are extremely virulent. The poison is so very potent that as small a quantity as ·23 mgm. is enough to be a fatal dose to a human being. In strychnine poisoning we probably should want something like 70—100 mgm. before the dose would prove fatal. While many kinds of wounds may contain the organism, it is not the most severe that are necessarily the most virulent. A trifling prick may be sufficient to cause a rapidly-fatal development. At the Fourth of July celebrations in New York many deaths used to occur from tetanus caused by the little punctured wounds resulting from the use of toy pistols. At the St. Louis Hospital in New York they now at once inject anti-tetanus serum in all doubtful cases, and in all such wounds, with the result that tetanus very rarely develops. In France, however, they have not had such uniformly good preventive results.

Kitasato showed that the organism develops locally at the seat of infection, and is not found in the blood or tissues elsewhere. Its virulence is much increased if other organisms are developing at the same time so as to use up the oxygen in the tissues.

The toxin has a great affinity for the nervous tissues, which are capable of fixing it loosely. The poison travels up by the axis cylinders, especially of the motor nerves, to the anterior horns of the spinal cord, and it is mainly by this route that absorption takes place during the first twenty-four hours. From thence it spreads and infects the other nervous tissues. The symptoms are therefore at first local and later general. The conducting power, however, depends on the integrity of the nerve.

Marie and Morax, in 1902, and Mayer and Ransome, in 1903, have shown that, if a sciatic nerve be divided and tetanus poison injected into the limb, it will be found that the peripheral part will fix the poison as well as if it had not been cut, provided not more than three days have elapsed, but it will not do so after six days. Now the axis cylinders take from one to three days to degenerate.

If the nerve be divided at the knee, and the sciatic nerve be inserted into a mouse, no tetanus will result, as the proximal nerve is free from poison, but if it be divided at the hip, tetanus will ensue. Hence the poison travels up by the peripheral terminations, and not by the capillaries. Also, no symptoms ensue in the mouse if the nerve is inserted in less than an hour after the poison has been injected. There is a continuous centripetal circulation of the poison, which passes in a rabbit out of the sciatic nerve in two hours.

For twenty-four hours at least the greater portion of the poison is absorbed by the peripheral nerves, and but little by the general circulation.

If the spinal cord be divided, the spasm is limited to the parts supplied by the nerves below the section. Brain tissue, but not the peripheral nerves, can neutralize the poison if mixed up with it previous to injection, but antitoxin has a greater affinity for toxin than brain matter has. Still, if the toxin has once reached the brain, it will require a very large amount of antitoxin to dissociate it again.

The poison acts very differently upon different animals. Experimentally it is found that guinea-pigs are much more susceptible than mice, and mice than rabbits; moreover, the injection of the poison into insusceptible animals is capable of setting up the development of an anti-toxin. This great discovery was made by Behring and Kitasato in 1890, and the same workers showed that the anti-toxin neutralised the toxin. The great question, upon which we are even yet not quite clear, is whether the fixation of the poison by the nervous tissue is the same as the union which takes place between the toxin and the anti-toxin. This does not seem to be the case; there is no doubt the toxin has much more affinity for the anti-toxin than for the nervous tissue. The conclusion at which we have at present arrived is that when anti-toxin is administered to a patient it is capable of neutralising any free toxin, but is not capable, unless given in enormous quantities, of turning out any toxin already in the nervous tissues. As a prophylactic, therefore, it is of use, but in the curative stage its value is very small indeed. Out of the forty-five cases tabulated, eleven recovered; and of these eleven, five had serum treatment, four surgical treatment, and two medical treatment. Of the cases which ended fatally, nineteen had serum. The percentage of cures in the serum cases was

twenty, and in the non-serum cases twenty-eight, the number of cases being so small that it would be wise not to draw any deduction, except that the serum is not of striking value. In considering the mortality of the cases, a great deal of importance attaches to the length of time which has elapsed between the original injury and the development of the first symptoms. If the symptoms develop within two or three days the case is almost invariably fatal, but if the patient survives twelve or fourteen days the chances of improvement are very much greater. The question of prognosis will therefore depend more upon the date on which the first symptoms appeared than upon any treatment that may be adopted. The symptoms may all be produced by the injection of the toxin, without introducing any organisms.

In tetanus we generally find that the spasm begins locally at the seat of injury. The incubatory period varies from four days upwards, four-fifths of the cases occurring within a fortnight. The commonest of the early symptoms are stiff neck and sore throat. The risus sardonicus generally appears with inability to open the jaws. The appearance of the patient is very characteristic. He looks much older than his age, has a wrinkled forehead, his eyelids are only half open, and the lips are tightly drawn over the clenched teeth. The spasm quickly becomes general. The patient holds his chest rigid, his abdomen is as hard as a board, not infrequently his legs are extended, and his arms semi-flexed. The first of the patients of whom I have spoken had a considerable amount of pain; the others had not. Generally speaking, the spasm does not involve the hands and feet. Frequently there is profuse sweating, and occasionally rigors. As the disease progresses, the patient becomes subject to periodic attacks of clonic spasm, which may be brought on by the slightest breath of wind. It is impossible to get the patients to take much food on account of the spasms, which are so violent that occasionally the muscles rupture. I have gone through the records of the temperatures of a good many cases, and find that in a large number the high temperature was due to the condition of the primary wound. In recent years, when suppuration of the wound is of much less frequent occurrence, there is less severe pyrexia than formerly. In the most severe cases, as a rule, the temperature runs up to 104°–106° F. The first of the three cases I have brought before you had a temperature of 103·4°; in the other the temperature was scarcely raised at all. In more than half the cases in which there is pyrexia it is due to the wounds; still very persistent and prolonged muscular spasm is capable of inducing pyrexia.

As to the prognosis of those cases in which the symptoms come on within seven days the great majority die within forty-eight hours. In the cases which come on after ten days the mortality is about twenty-five per cent. The cause of death is generally asphyxia, from fixation of the chest, but occasionally death takes place from cardiac failure, the pulse becoming more rapid and more feeble. In most, however, the respiration stops before the pulse.

There should be little difficulty in making a differential diagnosis between tetanus and the other conditions with which it is likely to be confused, such as strychnine poisoning, hydrophobia, meningitis, clenched jaws from a local lesion, hysteria, and tetany. Strychnine poisoning is always an acute condition, and if it is known that violent spasms have lasted for more than a few hours, there is strong presumption that they are not due to strychnine, as the poison is generally fatal within two or three hours. The spasm in strychnine poisoning is intermittent; there is no rigidity between the attacks, and the jaws are not particularly involved. In hydrophobia the spasm which is induced while attempting to drink water, with the hallucinations and the excited condition of the patient, present a different picture. In meningitis the distinction may be made on clinical grounds, the delirium, the mental disturbance, the twitching and the flushing of the face being quite different from the rigidity of tetanus, nor is the spasm of the jaw so well marked. A lumbar puncture will clinch the diagnosis. In hysteria again, the violence, the amplitude of the convulsions, the erratic and often rhythmical nature of the movements suggest the true nature of the case. Moreover, there is no trismus. In tetany the peculiar position of the hands and, in local jaw disease, the examination of the mouth, ought to be sufficient to furnish a distinction.

TREATMENT.

As the poison is only produced locally, it is most important to excise the wound freely. The patient should be kept free from all disturbances, and food may require to be given per rectum or by a nasal tube, and, if need be, under an anæsthetic, if the patient is unable to swallow. The results of present-day treatment are not very much superior to those obtained many years ago. It used to be of a very violent

character, as you will find if you will read Sir Thomas Watson's delightful lectures, which you ought all to peruse at your leisure. A case is recorded in which four ounces of laudanum were given daily for twenty days, and the patient ultimately recovered. In other cases the most vigorous venesection was carried out, and a certain proportion of cases recovered. Some years ago, when I was a surgical dresser, a boy was in the ward with tetanus to whom we administered morphine subcutaneously every two hours day and night for a fortnight. He took 30 grains during that time with obvious benefit, and ultimately recovered. Dr. Taylor also records cases in which a large amount of chloral, 180 to 300 grains, were given daily. But when the treatment has been limited to sedatives the recoveries have been very few. At the same time, there can be no question that repeated doses of morphia and chloral and chloroform give great relief and assist in the cure.

The evidence in favour of the use of the antitoxic serum prophylactically is strong. When a wound is particularly dirty, or damage has been done by a pistol or gun, it is wise to give 10 c.c. or more, locally at once.

There is still a lack of agreement as to the dose to be used when symptoms have developed; the dose recommended by the Lister Institute of their serum is 10 to 20 c.c., but Dr. Macconkie tells me that they have had more successful results with doses of 100 to 200; unfortunately the serum in these doses is expensive. No uniform system of standardization has yet been adopted, and many sera are not found to be of the strength indicated on the bottles.

Rosenau and Anderson,* of the Public Health Department, Washington, have shown that it is possible to keep both the toxin and the antitoxin of constant strength at a low temperature in a dry state, and since 1902 have used a simple method of maintaining a constant standard for the serum sent out by the New York laboratories, and have tested the sera on the European market with very variable results.

The serum is more efficient if injected into the spinal canal after drawing off some fluid and also intravenously as well as locally.

Some trephine the skull and inject the fluid into the cerebrum and ventricles. We have had a few cases in the hospital in which this was done, but they all proved fatal.

One of my cases was that of a woman who fell down on a brick and fractured her forearm, driving in at the same time a piece of the brick; this was overlooked, and the arm was put up in a splint. She developed tetanus within four days. Mr. Dunn trephined her skull on both sides, and we injected 20 c.c. of serum on each side, but the disease was not retarded; she died about three days after the onset of the symptoms and seven days after the original injury. The objection to the method is that the injections have probably to be repeated daily, and it is very probable that hæmorrhage will be set up and damage done to the brain.

On looking through the reports of cases in the hospital, I find that there are three in which large amounts of serum were used. One was that of a boy aged 15, who had 400 c.c. given subcutaneously, and ultimately recovered. His first symptoms came on a week after the injury. Another case which recovered was that of a man whose symptoms came on eleven days after the injury, and who had 250 c.c. A third case ended fatally; the dose in this instance was 400 c.c. So that two out of the three patients who had very large doses recovered.

Other treatments consist of the injection of eucaine or stovaine into the spinal canal, and also of sulphate of magnesia. Several cases are on record in America in which 2–4 c.c. of a 25 per cent. solution of sulphate of magnesia has been injected into the spinal canal. The result is seen within twenty minutes to one hour, when the muscles of the legs and abdomen relax and become paralysed. For some hours there is no rigidity, but the symptoms reappear about eight hours afterwards, and in twenty-four hours they are just as bad as ever. The injections are then repeated. One case, however, thus treated died from the most profuse bronchorrhœa. This can be prevented by injections of atropine. Although there is a certain amount of danger about the treatment, it promises to be of considerable value. Out of thirteen cases treated by sulphate of magnesia recorded by one authority, six have recovered; another reports two cases thus treated which died. Of the nineteen cases recorded altogether, there have been eleven deaths, which is a rather better result than has been obtained by other means. The injection of carbolic acid subcutaneously has been successfully employed both with tetanus and plague. In the former as much as 20 to 30 grains has been injected with good results, but in the majority it has been unsatisfactory. In future, I should inject at least 100 to 200 c.c. of serum daily, and if the case were doing badly, possibly also 4 c.c. of sulphate of magnesia solution intraspinally.

*Rosenau & Anderson. Hygienic Laboratory, Bulletin 4, 3rd March, 1908. Treasury Department, Washington.

FORTY-FIVE CASES OF TETANUS IN GUY'S HOSPITAL, 1889—1909.

Number of Cases	45	
Recoveries	11	25 per cent.
Out of 11 recoveries	5	Had serum.
	4	Surgical treatment without serum.
	2	Medical treatment only.
Out of 34 deaths	19	Had serum.
Number of cases treated by serum ...	24	No serum 21
Number of serum cases which recovered ...	5	21 per cent.
Number of cases which recovered without serum	6	28·5 per cent.

TWENTY-FOUR CASES WITH A DEFINITE INCUBATION PERIOD.

Number of days after injury of onset.	Number of days after injury of treatment.	Result.
A. 4	4 (serum)	Death — 7 days after injury. 3 „ onset.
5	—	Death — 7 „ injury. 2 „ onset.
6	7 (serum)	Death — 11 „ injury. 5 „ onset.
6	7 (cauterisation)	Death — 7 „ injury. 1 „ onset.
6	6	Death — 8 „ injury. 2 „ onset.
6	15 (excision)	Recovery.
7	8 (serum)	Death — 9 days after injury. 2 „ onset.
7	9 (serum)	Recovered.
8	10 (serum)	Death — 9 days after injury. 3 „ onset.
9	11 (serum)	Death — 13 „ injury. 4 „ onset.
9	10 (serum)	Recovery.
9	11	Death — 17 days after injury. 8 „ onset.
9	—	Death — 20 „ injury. 10 „ onset.
B. 11	20 (amputation)	Recovery.
11	16 (excision)	Recovery.
14	14 (cauterisation)	Recovery.
14	14 (amputation)	Death — 14 days after injury. 1 „ onset.
15	16 (serum)	Death — 18 „ injury. 3 „ onset.
15	21 (medical)	Death — 26 „ injury. 1 „ onset.
16	19 (serum)	Death — 21 „ injury. 5 „ onset.
17	22 (serum)	Recovery.
26	28 (serum)	Death — 29 days after injury. 3 „ onset.
30	33 (serum)	Death — 37 „ injury. 4 „ onset.
2 months	(medical)	Recovered.

A.—Under 10 days, 13 cases, 3 recoveries (6, 7, and 9 days). 7 Serum, 2 recoveries.

B.—Over 10 days, 11 cases, 5 recoveries. 5 Serum, 1 recovery.

LIST OF CASES.

Sex and Age.	Wound.	Onset.	Treatment.		Course and Result.
			Surgical.	Medical.	
M. 15. 1907	Foot. Jan. 19 ...	Jan. 26 ...	Amputation. 10 c.c. into cord. 400 c.c. subcutaneously. Jan. 28	Chloral hydrate ...	Improvement on Feb. 7. Discharged Feb. 12, quite well.
F. 10 days. 1907	None	Jan. 24 ...	None	Chloral. Jan. 26 ...	Died 6 hours after admission.
M. 39. 1907	Foot. May 29 ...	June 9 ...	Excision of area. June 14	250 c.c. subcutaneously	Improv'ment began June 23. Disch'd well on July 3.
M. 56. 1907	Multiple sores ...	July 16 ...	400 c.c. subcutaneously. July 22	Pot. brom.	Died, Aug. 4.
M. 23. 1906	Finger. About Feb. 3	Feb. 18 ...	Amputation. 30 c.c. into brain. Feb. 19	Chloral, pot. brom., morphia, chloroform	Died, Feb. 21.
F. 9 days. 1906	Umbilical suppuration	June 15 ...	None. June 15	Chloral and bromides per rectum	Died, June 17.
M. 63. 1905	None	Aug. 16 ...	10 c.c. into cord. Aug. 17	Chloral and bromides per rectum. Morphia, chloroform	Died, Aug. 18.
M. 28. 1905	Finger. Aug. 12 ...	Aug. 18 ...	Excision. 10 c.c. into cord. Aug. 18	Morphia, digitalis, hypodermically. Chloroform	Died, Aug. 20.
M. 17. 1905	Finger. Oct. 26 ...	Nov. 9 ...	Amputation. Nov. 9 ...	Morphia, oxygen, ether	Died, Nov. 9.
M. 15. 1905	Frequent scratches...	Feb. 4 ...	30 c.c. subcutaneously. 30 c.c. into cord. 30 c.c. subcutaneously. Feb. 6	Chloral, morphia ...	Died, Feb. 7.
F. 9 days 1905	Umbilical suppuration	April 26 ...	Lysol. April 29	Pot. brom., chloral...	Died, May 1.
M. 38. 1904	Old sinus in chest from bullet wound	April 26 ...	Sinus scraped. 20 c.c. subcutaneously. April 29	Chloral, pot. brom....	Died, May 2.
M. 8 days 1904	Umbilical suppuration	June 19 ...	10 c.c. injected into anterior fontanelles. June 22	Chloral per rectum. Chloroform	Died, June 25.
M. 7. 1904	Two carious molars extracted on Aug. 14	Aug. 22 ...	20 c.c. subcutaneously. Aug. 24	Opium, pot. brom. 180 grs. per diem	Improv'ment began Sept. 18. Disch'd well Sept. 27.
M. 65. 1904	Recent suppuration of a corn	Sept. 7 ...	Corn excised. Sulphur. Sept. 13	Bromides, chloroform	Died, Sept. 17.
F. 29. 1903	Palm of hand. Jan. 6. Recent mammary abscess	June 12 ...	Cauterised with silver nitrate. Jan. 13	Morphia	Died, 11 hours after admission, Jan. 13.
M. 20. 1903	Thumb. May 26 ...	June 6 ...	Amputation. June 15 ...	Bromides, morphia, chloroform, hyoscine	Improv'ment began June 25. Disch'd July 15. Rigidity had not quite gone

LIST OF CASES—*continued.*

Sex and Age.	Wound.	Onset.	Treatment.		Course and Result.
			Surgical.	Medical.	
F. 27. 1903	None found ...	Aug. 2 ...	None	Bromides, morphia, paraldehyde, chloroform, hyoscine, hydrobromide (poisoning symptoms)	Discharged, Sept. 15. Masseters and abdominal muscles still contracted.
M. 10 days 1902	Umbilical suppuration	Dec. 15 ... (Two days before admission)	Excision round umbilicus. 2 c.c. injected into each end of coronal suture. Dec. 18	Haustus chloral ...	Died, Dec. 19.
M. 38. 1901	Gelatin injections for thoracic aneurysm. July 19, 25, 27, 30: Aug. 15	Aug. 16 ... Pains in back Aug. 20 .. Trismus	Abscess opened, pus escaped. Aug. 20	Chloroform ...	Died, Aug. 21.
M. 33. 1901	Gelatin injections for thoracic aneurysm. July 17, 19, 25, 27, 30, Aug. 2, 9, 15	Aug. 20 ...	Abscess opened, pus evacuated. Aug. 20	Chloral, oxygen ...	Convulsions quickly developed. Died, Aug. 21.
F. 54. 1900	Nail in foot. Mar. 29	April 6 ...	10 c.c. under dura mater, 10 c.c. subcutaneously. 10 hours later, 20 c.c. subcutaneously. April 8	Chloral, bromides ...	Died, April 9.
F. 45. 1900	Compound fracture of forearm with impaction of a piece of brick	4 days later	Both sides of skull trephined. 20 c.c. injected into each lateral ventricle and repeated next day	Morphia, chloroform	Death in seven days
M. 10. 1900	Foot. Aug. 20 ...	Sept. 3 ...	Wound cauterised. Sept. 3	Pot. brom., morphia	Gradual improvement and recovery.
F. 11. 1900	Toe. Oct. 12 ...	Oct. 21 ...	Wound excised. Oct. 23. 20 c.c. serum, subcutaneously. Oct. 23 and 24	Chloral, pot. brom.	Died, Oct. 25.
— 1899	— (Not found)	—	—	—	—
M. 56. 1898	Arm. June 26 ...	July 11 ...	(None mentioned)	Ammon. brom., ammon. carb., chloral, morphia. July 17	Died, July 22.
M. 42. 1898	Abrasions of indefinite date. Gumboil. Aug. 21	Aug. 23 ...	(None mentioned)	Amyl nitrite, pot. brom., chloral	Died, Aug. 28.
M. 6. 1897	Knee. Oct. 13 ...	Oct. 20 ...	Wound excised. Oct. 21 50 c.c. into vein; 60 c.c. ditto. Oct. 22	Ammon. brom., chloral. Per rectum and mouth	Died, Oct. 22.
M. 29. 1896	Toe. About Feb. 10	March 10 ...	2 gms. serum. Amputation. March 13. 2 gms. serum; 20 gms. serum. March 14.	Morphia	Died, March 14.
M. ? 50. 1896.	Finger. April 3 ...	April 12 ...	Amputation. April 14. 2 gms. of serum subcutaneously. April 13	Chloral, pot. brom., amyl. nitrite	Died, April 20.

LIST OF CASES—*continued.*

Sex and Age.	Wound.	Onset.	Treatment.		Course and Result.
			Surgical.	Medical.	
M. 6. 1896.	No history. Toothache on July 16	July 17 ...	None	Chloral, bromides, chloroform. July 18	Died, July 19.
M. 9. 1895.	Toe, April 5. Leg, April 21. Toe, May 3	May 5 ...	May 5. Wounds scraped. „ 6. Serum 15½ gr. subcutaneously. „ 7. Ditto) a.m. Ditto) p.m.	Chloral, pot. brom....	Died, May 7.
M. 54. 1895.	Foot. Dec. 26 ...	Jan. 12 ...	Excision around wound. 120 c.c. in 12 lots under skin. Jan. 17	Morphia	Improv'ment began Jan. 21. Disch'd well, Feb. 22.
M. 4. 1895.	Toe. June 2 ...	June 8 ...	June 9. 10 c.c. under skin „ 10. 25 c.c. „ 11. Serum 15½ grs. „ 12. „ „	Chloral	Died, June 13.
F. 7 days. 1895.	— —	Aug. 20 ...	Serum grs. 12 into muscles of back. Aug. 22	— —	Died, Aug. 22.
M. 38. 1894.	Foot. April 23 ...	April 29 ...	Wound excised. May 8 ...	Chloral	Improv'ment began June 2. Disch'd on June 21.
F. 16. 1891.	Foot. End of Aug.	Beginning of Sept. (not admitted till Nov. 21)	— —	Salicyn, pot. brom., morphia, atropine, physostigmine	Died, Jan. 23, 1892.
M. 7. 1889.	Finger. Two months previous	April 3 ...	— —	Chloral	Discharged May 26.
F. 43. 1909.	Foot. Oct. 9 ...	Oct. 13 ...	Oct. 13. Amputation ... „ „ 20 c.c. into cord „ „ 20 c.c. into vein „ 14. 40 c.c. into vein „ 16. 50 c.c. into vein	Morphia, chloroform, chloral, atropine, ether, brandy	Died, Oct. 16.
M. 48. 1909.	Toe. Sept. 20 ...	Oct. 6 ...	Oct. 9. Amputation ... „ „ 20 c.c. into vein „ „ 20 c.c. cord „ 10. 20 c.c. into veiu „ „ 20 c.c. cord „ 11. 20 c.c. into vein	Morphia, chloroform, ether, chloral, strychnine, brandy	Died, Oct. 11.
M. 36. 1908.	Old ulcers of leg ...	July 23rd ...	July 31. 10 c.c. brain substance „ 10 c.c. thigh Aug. 1. 10 c.c. subcutaneously „ „ 10 c.c. into cord „ 2. 60 c.c. subcutaneously „ 3. 20 c.c. „ „ 4. „ „ „ 5. „ „ „ 6. „ „ „ 9. „ „	Morphia	Improvement from Aug. 8. Discharged, Aug. 24.

LIST OF CASES—*continued.*

Sex and Age.	Wound.	Onset.	Treatment.		Result.
			Surgical.	Medical.	
M. 5. 1907.	Crushed fingers Aug. 25 ...	Sept. 3 ...	Aug. 25. 1st amputation „ 30, 2nd „ Sept. 4, 3rd „ „ „ 20 c.c. subcutaneously „ „ 10 c.c. brain „ 5. 20 c.c. subcutaneously „ 7. 10 c.c. brain „ „ 20 c.c. subcutaneously „ 8. 10 c.c. subcutaneously	Chloral, oxygen ...	Improvement from Sept. 9. Discharged, Oct. 15.
M. 57. 1903.	Scalp. Oct. 14 ...	Oct. 23 ...	Two teeth extracted ...	—	Died, Nov. 3.
M. 43. 1900.	Crushed hand Sept. 5 ...	Oct. 1 ...	Oct. 3. Arm amputated „ „ Serum into cord „ „ „ subcutaneously „ 4. „ „	Morphia, chloral ...	Died, Oct. 4.
M. Adult. 1899.	Fracture of arms, legs, and ribs. June 21	June 26 ...	—	—	Died, June 28.

Dental Notes.

On Friday, December 10th, a meeting of the Dental Society was held in the Physics Theatre, with Mr. Aubrey in the chair. There was one casual communication, and, after a brief discussion, Mr. Neft read a paper on "The Dental Problem of the Day." The subject was really a solution of the Dental Quack difficulty by the Nationalisation of the Dental Profession, and Mr. Neft explained the varieties of quackery and the great need that there was for reform. The way in which nationalisation was to be brought about was not fully explained, and a considerable number of the audience were rather left in the dark as to the real meaning of the word. The discussion which followed was not up to the very high standard of the meetings, but several very interesting points were brought up. A certain section of the audience were rather inclined to quarrel with Mr. Neft, not for what he said, but for opinions which he was supposed to hold, but had said nothing about at the meeting. Over 100 members were present, which is a record attendance, the nearest approach to this being 94, about ten years ago. The attendance at the society's meetings has been well above the average, and it is to be hoped that the present popularity of the society will be maintained throughout the session.

On Friday, January 14th, at a meeting of the Dental Society, held in the Physics Theatre, a most interesting paper was read by Mr. Shepherd, entitled "Some Observations and Experiments in connection with the construction of a Luerson's Obturator." In illustration of the paper the author showed many specimens of obturators made with different rubbers which had been vulcanised for different periods of time, some having been vulcanised containing alcohol, some containing water, and others neither. As expected, those containing the alcohol proved far more successful than the others.

Mr. DOWSETT, although unavoidably absent, lent some very interesting experimental specimens of obturators.

The PRESIDENT, and Messrs. OLLIS and NEFT also spoke.

Two casual communications were shown by Mr. Shepherd. The first one was a four-rooted upper wisdom tooth, and the second a three-rooted right lower first molar, of which the anterior root was almost bifid.

The Fifteenth Annual Dinner of the Dental Society will be held at the Trocadero, on February 12th, 1910, at 6.30. The President, Mr. Aubrey, will occupy the chair. Application for tickets (6s. 6d.) should be made before February 7th to the Secretary, S. Wilson Charles, Guy's Hospital, S.E.

Reviews, etc.

Books for review should be addressed to The Editor, Gazette Office, Guy's Hospital, S.E. Their price should in every case be stated.

Proceedings of the Royal Society of Medicine, Vol. III., No. 2, December 1909. (Longmans, Green & Co.) Price 7s. 6d. net.

In the Section of Anæsthetics, Dr. Orr records a case of heart massage in heart failure during anæsthesia, with recovery, and discusses the history of this procedure, showing how it has been derived from experiments on animals. The first reported successful case in the human subject was Lane and Starling's case in 1903, where heart massage was used to revive a patient who collapsed under ether during an operation in the appendix region. Dr. Orr's case was one of white syncope under chloroform, and it happened that the site of the projected operation was the epigastric region. Three or four minutes after the stoppage of the heart the surgeon made his incision and commenced heart massage. Dr. Starling, in the discussion, described a successful case in a child where massage was performed through the parietes.

In the Clinical Section Messrs. Bruce-Porter, Lockhart Mummery, and Dr. Hale White report a very interesting case of "Pneumococcic Colitis with Hyperpyrexia; Severe Hæmorrhage treated by Appendicostomy." The diagnosis of pneumococcal colitis was made during life from the sudden onset, the high temperature, the extreme loss of blood, and the appearance of the mucous membrane as seen with the sigmoidoscope, and was confirmed by bacteriological examination. Appendicostomy was performed, and seems to have been very successful in arresting the hæmorrhage. Twelve hours after the operation, however, the patient began to be hyperpyrexial. This symptom was successfully treated by cold sponging and by running iced water through the colon. After this, recovery seemed progressive until twelve days later, when the patient suddenly succumbed from heart failure.

The Section for Electro-Therapeutics contains a useful paper by Dr. E. R. Morton on the "Treatment of Nævi by Electricity, Cautery, and Refrigeration." He deals more particularly with the last-named method, in which a crayon of solid carbon dioxide is applied to the nævus, and Dr. Morton has found the results by this method so successful that he now treats more cases by it than by all the others put together. "The ultimate result," he says, "is a pale, soft, pliable and elastic scar, which is as good as any produced by any other caustic agent, or even radium."

Drs. Craven Moore and Ferguson contribute to the Medical Section a paper on "The Rôle of Fats in the Treatment of Disorders of the Stomach," and a discussion on the subject was opened by Dr. Hertz.

The Neurological Section contains the Hughlings Jackson Lecture by Sir William Gowers on "Special Sense Discharges from Organic Disease."

Of special interest to Guy's men is Dr. Eyre and Mr. Lewin Payne's paper on "Some Observations on the Bacteriology of Pyorrhœa Alveolaris, and the Treatment of the Disease by Bacterial Vaccines" in the Odontological Section, and that on "The Action of some Diuretics" by Dr. H. H. Dale and Mr. P. P. Laidlaw in the Pharmacological Section.

Literary Notes.

Among the forthcoming new books and editions the following are announced by Messrs. J. & A, Churchill:—

Next week will be issued "The Practice of Surgery," by W. G. Spencer, Surgeon to the Westminster Hospital, and G. E. Gask, Assistant-Surgeon to St. Bartholomew's Hospital. This work will contain 1,200 royal octavo pages, but its predominating feature will be the number and excellence of its illustrations, amounting to 700 black and white figures, 28 skiagram plates, and 20 coloured plates. The Museums of St. Bartholomew's Hospital and the Westminster Hospital, as well as other Museums, have been freely drawn upon for good specimens.

In addition to the above, a new edition of "Galabin's Midwifery," under the Editorship of the Author and Dr. G. F. Blacker, Obstetric Physician to University College Hospital, is going through the press, and will be in the hands of students before the Summer Session. This book, which has had a great vogue among generations of past and present students, is being almost rewritten. Dr. Lawrence, Curator of the Museum at University College Hospital Medical School, has prepared most of the drawings.

Another popular work is that on "Diseases of Children," by Drs. Goodhart and Still. For the first time in its long history, illustrations will be introduced. The work will be published in February.

Papers, etc., Received.

Oxide of Zinc: its Nature, Properties and Uses.—By J. Cruickshank Smith, B.Sc., F.C.S. (Trade Papers Publishing Co., Ltd.) Price 2s.

No one who has seen anything of hospital practice needs to be reminded of the serious ravages which lead often makes in the health of painters and others whose work brings them into contact with it. If further proof in the indictment of lead were needed, it may be found in the fact that lead poisoning has been scheduled as "an accident" under the Workmen's Compensation Act, 1907, and that the use of white lead has been forbidden in several Continental countries, notably France. It is therefore to the advantage of employer as well as

employee that the use of lead should be, as far as possible, restricted. The book before us is an impartial account of the advantages and disadvantages of oxide of zinc as a substitute for white lead, with special reference to the making and application of paint. The hygienic argument is the strongest possible in favour of oxide of zinc as opposed to white lead, but it is here shown also that the safer pigment possesses distinct advantages of its own in durability and as a white base for making up tints with other pigments.

An English Handbook to the Paris Medical School.—By A. A. Warden, M.D. 2nd Edition. (J. and A. Churchill.) Price 2s.

This little book, by a visiting physician to the Hertford British Hospital in Paris, should prove invaluable to the many English-speaking students who desire a handy guide to the hospitals of Paris, in order that they may make use, to the best advantage, of the unrivalled field for post-graduate work which the city has to offer in certain branches of medical science.

Sport.

Rugby Football.

GUY'S v. ROSSLYN PARK.

This return fixture took place at Richmond on Saturday, January 8th. Neither side were at anything like full strength, but for all that an excellent and most enjoyable game took place. Roberts was playing for England at Twickenham; Stringer was also at Twickenham, acting as reserve for the South. It is only fair to add that Stranack was chosen to play for the South in the former trial, but could not do so, as he developed a most unfortunate attack of influenza, and probably thereby lost his opportunity of getting into the final Twickenham trial. It is very noticeable, not to say remarkable, how many men of Guy's are chosen as reserves in the trials and also in the International matches. Speaking of recent years, one can only write with the keenest disappointment that McEvedy, who richly deserved a cap, never gained one. He was chosen as reserve at least four times for England. O'Brien was another reserve man. Alcock, after playing for England against the South Africans, was reserve on one or two occasions subsequently. Stringer was last year asked to go in the same capacity to Ireland with the English team. In the trials this year at Birkenhead, Stranack was reserve for England, eventually coming into the side. Stranack and Hind at the first Twickenham trial, and Stringer in the second, were reserves, and to finish the list, Roberts was chosen reserve forward in the International against Wales on the 15th. The time is coming when hospital players will get proper recognition, but though the process has been slow, it cannot be much longer delayed.

I must apologise for not remaining at Richmond, but to return there: the game was hard and fast, and if only Guy's had been able to give and take passes with a little more accuracy, they would have run up a good total. As it was, they had to content themselves with a win of 1 goal 1 try to 1 penalty goal.

Rosslyn Park drew first blood, as their forwards worked well down the field, where offside against Guy's enabled Bensher to goal. This was all the scoring until ends were changed; after which Guy's were "on top" completely, but excellent tackling on the part of Rosslyn Park, and ill-luck and bad passing by Guy's kept the score down. Roe was almost over when pulled down; a like fate waited on Stokes, but he got rid of the ball to Medlock, who scored, and Stokes converted. Kennedy, Harkness, Medlock, and Parry Jones were all very near gaining tries, but the defence held until just about ten minutes before the end, when Kennedy got away splendidly from the pack and gained an unconverted try, leaving the final score: Guy's, 1 goal 1 try, Rosslyn Park, 1 penalty goal. Team:—

GUY'S.—G. E. W. Lacey (back); A. S. Roe, A. H. Harkness, H. Lee, A. L. Stokes (three-quarters); J. G. Saner, A. H. Medlock (halves); J. R. Hind, H. Hoby, W. S. Stranack, R. S. Kennedy, V. Glendining, T. D. Stout, Parry Jones, G. Gibb (forwards).

REMARKS.—Hind, Kennedy, and Stranack were the pick of a very good pack, Kennedy showing up well. Among the backs whose passing has been referred to, Harkness played an improved game.

GUY'S v. ROYAL NAVY (CHATHAM).

It was a great pity the Navy were unable to bring up a stronger side on Wednesday, January 12th, to Honor Oak Park, the most notable absentee being Lyon, the International full-back. Apart from his great value as a player, his personality imbues a side with confidence, and acts as a stimulant for further effort. As the game progressed it became quite evident that Guy's, weakly represented as they were, were in for a big total, the end bearing out very thoroughly this early promise, the final score reading 8 goals 4 tries to 1 try. The Navy full-back was lamentably weak; he had little idea of how to tackle, and the try-getters passed him again and again with ease. In fairness, it should be mentioned he was really a forward, doing duty for the occasion only in the (to him) novel position. But after half time he was displaced, and he afterwards played a jolly good forward game, eventually gaining the only try which the Navy could claim. In the first half Stokes (2), Stringer, Harkness, Lee, and Medlock, gained tries, the goals being kicked from easy positions by Lee (2), Hind, Stokes, and Roberts.

After ends were changed, Lieutenant Blair went full-back instead of Lieutenant Rogers, but though the former did his level best to keep the points down, Stringer (twice), Lee, Medlock, Kennedy, and Roberts, scored, Stokes kicking two goals and Kennedy one. For the Navy Rogers scored, and Lieutenant Moir failed

with the goal. One must point out that Assistant Paymaster Elstob hurt his shoulder, and had to leave the field for good after about fifteen minutes' play. But even had he played all through, it is doubtful if Guy's would have been in any way prevented from scoring, as they undoubtedly did, almost at will. Team:—

GUY'S.—G. E. W. Lacey (back); L. B. Stringer, H. Lee, A. H. Harkness, A. L. Stokes (three-quarters); C. H. Medlock, J. G. Saner (halves); G. R. Hind, C. S. L. Roberts, W. S. Stranack, R. S. Kennedy, V. Glendining, Parry Jones, J. Tweed, H. Sharpe (forwards).

ROYAL NAVY v. UNITED HOSPITALS.

If one may so put it, the Hospitals were too strong "fore and aft" for their opponents in this match at Queen's Club last Wednesday, eventually running out winners by 3 goals, 1 dropped goal, and 3 tries (28 points) to 1 dropped goal (4 points).

The Naval men had to play until close on half-time with fourteen men only; the absence of one man in the scrum handicapped them severely, and during this first half the Hospitals got the ball from almost every scrum, so that very open play, fast and interesting, was witnessed. The Navy scored first, Cooper dropping a very pretty goal, allowing with fine judgment for the sweep of the breeze. Shortly after, Stringer tried a fruitless drop at the other end. This was followed by various scrums in Naval territory, and at length a loose kick planted the ball with Macpherson, who ran determinedly for the line, just touching over the mark for a try. Adams kicked a splendid goal. Stringer next got away from midfield, and with rare pace he raced over the line, falling for a try, when but for a slip he would have reached the posts. Again Adams converted. The Navy were scarcely in the picture; the ball was always with the Hospitals, and from the centre of the field Adams and Heale got going, beating all but Lyon, but Heale adroitly handed to Whyte as Lyon tackled, and Gabe was under the posts with the third try, Adams kicking the goal. The missing Naval man now arrived, just in time to see Stringer tackled, after a good run, inches only from the line, by Lyon. Half-time was then taken.

Resuming, the sailors pressed for a time, and twice Cooper punted over for Lacey to touch down. Two or three forward rushes were stopped by the Guy's full-back, who played as pluckily as ever. Soon, however, the Hospitals reassumed the upper hand, Palmer making an opening for Macpherson to score in the corner. No goal resulted. Palmer himself scored the next try, a good swerving effort. Palmer had fed Macpherson assiduously, so it was but right he should try a little "on his own." Adams took the kick, right in front of the bar, but so near that it was easily charged down. A mark by Stringer almost ended in a dropped goal by the same player, who had hard lines not to score in a rush over the line. For a time the Hospital forwards, who played grandly, every man doing his share, bombarded the Navy defence, but it was left to the three-quarters to add to the score, Macpherson again crossing, but wide out (just previously Adams had dropped a good goal). Evans failed to majorise Macpherson's try, and no further scoring ensued.

Coombes and Heale had a real harvest of opportunities behind a winning pack, and the three-quarters used their chance admirably. The run of the game was distinctly to the right, so that Palmer and Macpherson were constantly on the move. Final score, as given above. Teams:—

THE ROYAL NAVY.—*Lt. G. H. D'O. Lyon (back); Sub-Lt. Dankwercht, Lt. G. L. D. Gibbs, Lt. G. N. Biggs, *E,-Lt. S. F. Cooper (three-quarters); Midshipman F. L. Boyd, Lt. E. Manners (halves); Sub-Lt. E. Power, Lt. C. J. L. Edis, Lt. C. H. Abercrombie, Lt. E. W. Kirkby, Lt. E. J. B. Tagg, E. Sub-Lt. Breeze, Lt. F. O'Brien Wilson, Sub-Lt. G. S. Brown.

UNITED HOSPITALS.—G. E. W. Lacey, Guy's (back); *A. C. Palmer, London, A. A. Adams, London, E. G. Macpherson, London, L. B. Stringer, Guy's (three-quarters); A. S. Heale, London, H. M. Coombs, Bart.'s (halves); G. R. Hind, Guy's, *H. Archer, Guy's, T. Harrison, Middlesex, C. S. L. Roberts, Guy's, A. H. Crook, Guy's, A. E. Evans, Bart.'s, H. Whyte, London, *H. J. Morton, London (forwards).

* An International.

Association Football.

GUY'S v. EVERSLEIGH.

Played on our opponents' ground on Saturday, January 8th. Guy's turned out one man short, and with a very weak team, no less than five members of the second eleven being called upon to fill up the team. There was a very useful wind blowing the length of the ground, and we were lucky enough to start the game with the wind at our backs. Though playing only four forwards, as soon as the game started Guy's made tracks for the Eversleigh goal, and very nearly succeeded in scoring. Guy's kept up the pressure, and although our opponents made a number of dangerous rushes towards our goal and nearly succeeded in scoring on several occasions, it may be fairly said that, in the first half, we monopolised the play to a great extent, and the score of 4–1 in our favour at half time, just about represented the play.

The ball had become very much knocked out of shape during the first half, and when we started the second half against the wind, our defence found some difficulty in landing the ball up the field. Consequently it was our opponents who did most of the attacking, and were not long in adding to their score. Our opponents continued to press, and had it not been for the indifferent shooting of some of their forwards the score would very soon have been level. However, Guy's were the next to score, Bevis sending in a magnificent cross shot from the left wing close to the goal line, which completely beat the goalkeeper. Eversleigh now took up the game in a most determined manner, and before the close scored once

more, a pleasant game ending with the score: Guys, 5, Eversleigh, 3. Team:—

GUY'S.—H. C. Rook (goal); H. R. Bastard, C. E. Rice (backs); W. Matthews, J. Ryle, V. T. H. Golledge (halves); R. M. King, S. W. Bevis, D. Wain, D. McManus (forwards).

REMARKS.—The goals for Guy's were scored by Bevis (3) and Wain, the former playing a splendid game all through; whilst the remaining goal was accidentally headed through the Eversleigh goal by one of their defences.

Pass List.

University of Cambridge.

DEGREE OF DOCTOR IN MEDICINE CONFERRED.

C. H. Rippmann, King's.

DEGREE OF MASTER IN SURGERY (M.C.)

C. W. Greene, Emm.; A. S. B. Bankart, Trinity.

THIRD EXAMINATION FOR MEDICAL AND SURGICAL DEGREES. MICHAELMAS TERM, 1909. PART II.

The following have now satisfied the Examiners in all three sections:—

L. Bromley, Caius.
A. B. Carter, Jesus.
H. L. Duke, Caius.
W. Ledlie, Christ's.
H. G. Rice, St. John's.
J. G. Saner, Caius.
C. S. E. Wright, Emm.

PART I.

J. B. Hance, Christ's.

SECOND EXAMINATION. HUMAN ANATOMY AND PHYSIOLOGY.

H. A. Ash, Pembroke: C. Warner, Pembroke; A. M. Zamora, Christ's.

University of London.

M.D. EXAMINATION—DECEMBER, 1909.

E. F. Milton; H. I. Janmahomed, University Gold Medal.

The following gentlemen were recognised as teachers of the University at a Meeting of the Senate, held December 15th, 1909:—

St. George's Hospital Medical School.—Francis E. Fremantle, M.Ch., F.R.C.S. (Hygiene), Dr. E. Ivens Spriggs (Pharmacology).

THE EDITOR will, at all times, be glad to consider articles or sketches, provided that they are accompanied by the writer's name and address, not necessarily for publication. Payment is a matter of arrangement, and the fees that the GAZETTE *can offer are merely nominal, but if the writer desires any remuneration that fact should be stated. Authors who desire reprints of their papers should make their own arrangements with the printers when they return their proofs.*

Change of Address.

F. Stanley Batchelor, F.R.C.S. Eng., from Moray Place, Dunedin, to 9, London Street, Dunedin, New Zealand.

Fleet Surgeon W. J. Bearblock, R.N., *Ramillies*, Home Fleet.

Kenneth Black, F.R.C.S. Eng., from General Hospital, Nottingham, to 30, Park Square, Nottingham.

R. B. Dawson, M.R.C.S. Eng., L.R.C.P., from Guy's Hospital, to Maiden Newton, Dorset,

A. Cradock Fry, M.B., B.C. Cantab., M.R.C.S. Eng., L.R.C.P., to Oxford House, Wokingham, Berks.

C. W. Greene, M.B., M.C., M.R.C.S. Eng., L.R.C.P., 80, London Street, Greenwich, S.E. Teleph. 874, Deptford.

G. H. K. Macalister, M.D. Cantab., from Guy's Hospital to the Lister Institute of Preventive Medicine, Chelsea Gardens, Chelsea Bridge Road, S.W.

W. P. Purdom, M.B., B.S. Lond., from 25, Park Hill Road, Croydon, to Sobraon, Brighton Road, Sutton.

John Tanner, M.D., M.R.C.P.E., F.L.S., from 19, Queen Anne Street, W., to 4, Claremont House, Lithos Road, Hampstead, N.W.

(The Editor will be very glad to receive a postcard with notes of any change of address.)

Appointments.

Civil.

BATCHELOR, F. STANLEY, F.R.C.S. Eng., has been appointed Honorary Surgeon, Dunedin Hospital, Dunedin, New Zealand.

HAMMOND-SMITH, A., L.D.S., has been appointed Honorary Dental Surgeon to the West Ham and East London Hospital.

MARTIN, J. BIRCH, L.R.C.P. Lond., M.R.C.S. Eng., has been appointed House Surgeon to the Birmingham and Midland Eye Hospital, Birmingham.

Naval and Military.

Fleet-Surgeon W. J. BEARBLOCK, R.N., has been appointed to the *Ramillies*.

Territorial Force.

Royal Garrison Artillery, Cornwall (Duke of Cornwall's). —Surgeon-Lieutenant E. G. ANDREW, to be Surgeon-Captain.

Birth.

ROBINSON.—On December 25th, 1909, at Plymouth, the wife of Gerald Robinson, F.R.C.S., of a daughter.

ED.—A. N. C.

GUY'S HOSPITAL GAZETTE.

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Calendar of Coming Events and Ensuing Take-in Weeks.

February.

Sat. 5. 1st XV. v. United Services (Home).
2nd XV. v. Rosslyn Park "A" (Away).
1st XI. v. Wellingborough (Away).
2nd XI. v. Old Citizens "A" (Home).

Mon. 7. Clinical Lecture by Mr. Steward (Laryngology), 1.15 p.m.
Physiological Society's meeting, 4 p.m.

Wed. 9. 2nd XV. v. Bedford Grammar School (Away).

Thur. 10. Messrs. Dunn and Rowlands' Take-in (Messrs. Lucey and Johnston).

Sat. 12. 1st XV. v. London Welsh (Home).
2nd XV. v. Hastings and East Sussex (Away).
Debating Society, Ladies' Night, 8 p.m.
Dental Society's Annual Dinner, Trocadero, 7 p.m.

Mon. 14. Clinical Lecture by Dr. Iredell (Actinotherapeutics), 1.15 p.m.

Wed. 16. Physical Society's Meeting, Paper by Mr. Mutch, 8 p.m.

Thur. 17. Sir Alfred Fripp and Mr. Turner's Take-in (Messrs. Lee and Duvivier).

Passim.

SEVERAL interesting and important topics relating to medical education were raised by speakers at the recent dinner of the Guy's London University Club. Dr. Spriggs touched on a pet theme of our own. He urged the desirability of freer communication between the various London medical schools, and said that under the present system a man from one hospital sees far too little of the work and teaching of the others. With reservations, we entirely agree. The case of a large hospital like Guy's is not quite the same as that of a smaller one like St. George's, which Dr. Spriggs, as its Dean, more particularly represents; but even at Guy's there are many lessons which we might learn from the other hospitals, and in return, we are fairly confident, we could teach them something. Under the present system we are apt to become self-centred and narrow in outlook; by learning something of the methods of other schools we could do no harm, and might do much good, and yet not necessarily sacrifice a fraction of our *esprit de corps*. In the older days of medical education in London there was this freer communication between school and school; the students were accustomed to go to one place for their anatomy lectures, to another for their surgery, according to the fame and popularity of the teachers. While we do not think that

this old system should, or could, ever be revived, we are convinced that some interchangeability of attendance at the different hospitals would bring with it many educational advantages.

It is good news to hear that an improvement in the College, which we urged the desirability of recently in these columns, is now being made. Electric lighting is to be installed in all the bedrooms and sitting-rooms; the work has already begun and will be completed in a few weeks' time. No doubt some grumblers may be found to complain of the noise and inconvenience while the alteration is being made, but the change will be greatly appreciated by residents, and will add much to the attractions of the College as a place of residence.

Next Saturday is the Annual Ladies' Night of the Debating Society. For some reason or other, it has hitherto been the custom with those who are responsible for choosing the subjects for debate to select a more or less frivolous subject for the ladies' night. This year, however, the Society is to discuss the following motion:—"That in the opinion of this House the subject races of England should be given a greater share in the internal government of their Countries." A sufficiently controversial subject, especially as some representatives of the "subject races" (is the phrase intended to include the Colonies, we wonder?) are among us at the hospital. Meanwhile, one gentleman residing in the College, we notice, displays in his window a bill to this effect:—"Are you going to be pushed out by the foreigner?"

We are asked to draw special attention to the time and date of the School Examination in Medicine, a full notice of which appears on page 55.

Inset in this issue will be found a portrait of Mr. William Ilbert Hancock, F.R.C.S., whose sudden death last week after an operation came as a sad shock to those old Guy's men who had been his contemporaries, or had been associated with him in after-life. An account of his many-sided athletic career as a student at Guy's, and his brilliant career as an ophthalmic surgeon, thus suddenly cut short by death, is contained on another page. Here we can only express our deep and sincere sympathy with the wife and children in their sad bereavement.

From the Gazette's Special Pathologist.

All specimens—particularly those of solid tissues—should be accompanied, if possible, by a short clinical and post-mortem history, and a postal order for 2s. 6d. An extra charge of 6d. per slide is made when prepared sections are to be forwarded.

Directions to be followed in sending *Diphtheritic Membrane*:—Remove as much of the membranous exudation as possible with a pair of forceps, which have been sterilized by boiling water. Place the exudation in a small, perfectly clean empty bottle, with a well-fitting glass stopper, and forward without delay. No preservative fluid should be used. The specimen must be accompanied by a Postal Order for 5s. A telegram will be despatched immediately the examination of the specimen is completed.

NOTICES.

V. J. H., Westcliff-on-Sea.—This specimen of sputum contains an extremely small number of tubercl bacilli. The bacilli were only detected after a prolonged search.

D. C. C., Rushden.—This specimen of sputum contains a little muco-pus, and no tubercle bacilli are seen to be present.

R. R. D., Maiden Newton.—The post-mortem examination of this pigeon shows in the pharynx and œsophagus several yellowish cheesy-like membranous patches—some about the size of a sixpence; no other abnormality was detected, the trachea appearing normal. The condition is known as the diphtheria of pigeons, but it is not caused by the Klebs Loffler bacillus. The present tendency is to associate it with a "filter passer."

H. L., Manchester.—This material consists of cancellous bone covered by thickened periosteum and mucous membrane. These tissues all show inflammatory changes, especially the periosteum, and the bone is hollowed ou into cavities some of which contain blood. The epithelium is desquamating, and the surface of the mucosa is rough and papillary. We find no evidence of a malignant growth, and regard the lesion as the result of some chronic infection.

Guy's Hospital.

Summary of Anaesthetics and Operations for the Year 1909.

THE number of cases in which general anæsthetics were administered was 5,390, and there were 17 cases of spinal anæsthetics, of which 7 were administered by staff anæsthetists, 7 by house officers, and 3 by Dr. Morton, an American doctor. Of the 5,407 administrations, 112 were for the purpose of dressings or examination, and 76 for extraction of teeth, while in 3 cases 2 operations were performed under 1 anæsthetic, and again in 3 cases no operation was performed, though the anæsthetic was administered. The total number of operations, therefore, was 5,219 in wards (Bright ward excepted), special departments, out-patient department, and surgeries. Three operations under anæsthesia were performed by physicians, and 1 by a house-physician.

Coroner's inquests were held in 5 cases in which it was thought that death might be attributable to the anæsthetic. In one of them a local anæsthetic only was employed, and the coroner said that no inquest need have been held; whilst of the remainder, 3 were regarded by the jury as cases "where the death occurred from, or was accelerated by the anæsthetic," and in the fourth case "the jury were of opinion that the death resulted from the shock of the operation, and was not due to the anæsthetic." Particulars of all these cases are given in the Appendix.

GENERAL ANÆSTHETICS.

The permutations and combinations of general anæsthetics have been no fewer than 92, and it would occupy too much space to set them out at full length. It may, however, be remarked that of the 5,390 administrations—

A.C.E. Mixture (given on a Rendle's cone, by the open method, or on a Skinner's mask) has been employed in 2,808, and A.C.E. Mixture, followed by other anæsthetics, in 417 administrations.

Chloroform, by itself, has been used 728 times, and followed by other anæsthetics, 211 times.

Ether, by a Clover's inhaler, has been given in 718 cases, by the open method in 391, and in combination with, or followed by other anæsthetics in 122 cases.

Ethyl chloride alone has been administered to 368 patients, and followed by other anæsthetics to a further 24.

Gas has been given 356 times, gas and ether 198 times, gas and oxygen 13 times, and gas followed by other anæsthetics 36 times.

SPINAL ANÆSTHETICS.

Novocaine	6	Tropococaine	6
Novocaine and mannitol with a little chlor. and ether ...	1	Tropococaine and Chloroform ...	1
Stovaine	2		17
Stovaine with a little chloroform ...	1		

ADMINISTRATION OF ANÆSTHETICS.

Staff anæsthetists have administered in 1,697 cases, house-officers and clinical assistants in 3,264, whilst the remainder of the 5,407 administrations were divided amongst the visiting staff, the resident surgical officer, and other qualified men.

OPERATIONS.

TABULATED ACCORDING TO WARDS AND DEPARTMENTS.

Astley Cooper ...	164	Mary	40
Cornelius	177	Stephen	53
Lazarus	288	Esther	45
Job	468	Queen Victoria ...	343
Naaman	285	Clinical	130
Luke...	273	Isolation	14
Patience & Samaritan	279	Out-Patients ...	875
Charity	288	Front Surgery ...	117
Dorcas	312	Back Surgery ...	19
Lydia	258		
Martha	290		5,219
Eye Wards	467		
Addison	34		

Turning to the general wards, it may be noted that the totals of operations are as follows:—

Surgeons	845
Assistant surgeons...	781
House-surgeons and assistant house-surgeons	596
Surgeons' dressers and assistant surgeons' dressers	725
Resident surgical officer	197

The remaining 23 operations, bringing the total up to 3,167, were performed by other operators.

It should, of course, be remembered that all operations in wards by dressers and resident staff are performed under the supervision of the resident surgical officer or of the surgeon in charge.

Operations in the Obstetric Department (Queen Victoria and Patience ward) number 371, of which 54 were performed under supervision by obstetric residents, 50 by the obstetric assistant, and 267 by the obstetric surgeons.

The operations upon ophthalmic cases in the wards number 180, of which 50 were done under supervision by ophthalmic dressers, 21 by the ophthalmic house-surgeons, 20 by the ophthalmic assistants, and the rest, with 4 exceptions, by the ophthalmic surgeons. It will, of course, be remembered that this account refers only to operations under general anæsthetics, and therefore by no means represents the total operative work in the Eye wards.

There were 408 operations upon throat cases in Job and Ruth wards, 78 by the surgeon himself, 263 by dressers, 58 by the clinical assistant, 7 by house-surgeons, and 2 by other operators.

Aural operations in Ruth and Barnabas number 96, of which 64 were performed by the surgeon in charge, 18 by dressers, 10 by the clinical assistant and house-surgeon, and 4 by other operators.

The operations in general out-patients number 511, nearly all of which were performed by dressers under the

supervision of the assistant house-surgeon or of the surgeon.

In the front and back surgery 119 operations were performed, 6 by the resident surgical officer, 29 by out-patient officers or house-surgeons, and the remainder by dressers.

In the special out-patient departments 4 operations were performed upon eye cases by dressers; 159 upon aural patients, 5 by the surgeon, and 154 by dressers; and upon throat cases 202, of which 197 were done by dressers, and 5 by the surgeon and clinical assistant. In the orthopædic department there was one operation performed, and that by a dresser.

APPENDIX.

Henry Francis C., æt. 57, was admitted for a strangulated umbilical hernia. Eucaine was employed as a local anæsthetic, and death occurred during the operation. At the autopsy the patient was found to have a fatty heart and cirrhosis of the liver. An inquest was held, and the coroner told the house-surgeon that he was sorry to have called him, as he had "misunderstood the case."

Phœbe C., æt. 44, was admitted for carcinoma of the breast, and before Mr. Dunn began the operation she died under the anæsthetic. The anæsthetic employed was chloroform, and it was administered by a staff anæsthetist. It was subsequently ascertained that this patient had been extremely reluctant to come into the hospital, having a conviction that she would die under the anæsthetic.

Louisa F., æt. 51, was operated upon for a malignant ovarian cyst. The operation was very difficult, and involved hysterectomy to control the hæmorrhage. It lasted about two hours. Ether was administered by the open method, the administrator being an assistant house-surgeon. The patient died just after the operation was finished, and five minutes after the anæsthetic had ceased to be given, and the verdict returned at the inquest was "Death from shock."

Frances F., æt. 47, was admitted on December 1st. Three weeks previously she had swallowed a fish bone, and since then there had been gradually increasing pain and difficulty in swallowing. There had never been any trouble in breathing. She had attended Out-patients a few days previously, when a full-sized œsophageal bougie was passed into the stomach. Shortly after admission an attempt was made to examine the throat with a laryngoscope mirror, but owing to the collection of saliva in the pharynx, nothing could be made out During the night the patient was absolutely unable to swallow anything, fluid or solid, but there was no stridor and no difficulty in respiration. Next morning, as it was thought that the fish bone might be the cause of the trouble, it was decided to give an anæsthetic and examine the pharynx and œsophagus with a Killian's tube. The anæsthetic used was A.C.E., administered on a Rendle's cone by a qualified clinical assistant, the take-in house-surgeon being also present. Shortly after the commencement of the anæsthetic the patient's colour became very bad, though no respiratory difficulty was noticeable. The anæsthetic was at once stopped, and the patient was then noticed to have a well-marked conjunctival reflex. The colour did not improve, and in about a minute the breathing had become very shallow. Laryngotomy was at once performed, artificial respiration was tried, and strychnine injected. After a few minutes of artificial respiration the patient made two or three shallow respirations. Artificial respiration was kept up, but no further efforts were made by the patient. The pulse was felt for a short time, and ceased after the spontaneous efforts at respiration. At the post-mortem examination a large retro-pharyngeal œsophageal abscess was found extending from the level of the hyoid bone above into the mediastinum. There was no trace of any fish bone.

Frank S., æt. 13, was admitted under Dr. Hale White, suffering from heart disease and adherent pericardium. As he had been under treatment and observation in the hospital for some months without any improvement, it was decided, with the consent of his parents, to try to afford some relief by removal of a small portion of the ribs over the heart. A.C.E. mixture was administered by a staff anæsthetist, and the patient died before the operation was begun.

Guy's Hospital London University Club.

THE Annual Dinner was held in the Oak Rooms at the Trocadero Restaurant on January 28th, 1910, at 7.30 p.m. Professor E. H. Starling occupied the chair. After "The King and the other Members of the Royal Family," the following other toasts were drunk: "The University of London," proposed by Dr. Spriggs, and responded to by Professor Starling; "Guy's Hospital," proposed by Mr. Handley, and responded to by Dr. Hale White; and "The Chairman," proposed by Dr. Forsyth, and answered, of course, by Professor Starling. The speeches were both witty and interesting, and were greatly appreciated. Songs were given by Messrs. Catto and Duvivier, and contributed to the pleasure of a very enjoyable evening.

At the Annual General Meeting which preceded the Dinner it was unanimously decided to send a message of deep sympathy to Mrs. Ilbert Hancock in her great bereavement.

Among those attending the Dinner were the following:—Visitors, Dr. Culver James, Mr. Reynolds Ray, Dr. Shillitoe; Members, Messrs. S. H. C. Air, F. F. Burghard, H. Catto, F. Durham, E. Duvivier, Dr. D. Forsyth, Mr. W. S. George, Dr. Albert Green, Mr. W. S. Handley, Dr. J. W. F. Jernell, Dr. Iredell, Dr. W. H. Lamb, Mr. A. E. Lees, Dr. T. D. Lister, Mr. R. J. Reynolds, Dr. E. I. Spriggs, Professor Starling, Dr. T. G. Stevens, Mr. R. Stout, Mr. T. D. M. Stout, Mr. R. H. J. Swan, Dr. Hale White, and Mr. Philip Turner.

In Clinical.

BY R. P. ROWLANDS, M.S.

A young woman was admitted on the fourth day of a typical attack of appendicitis, giving rise to spreading peritonitis. She was very ill, and her abdomen was getting considerably distended. There was shifting dulness in both flanks, and the abdominal wall in its lower two thirds was very tender and rigid. The abdomen was opened through the right rectus, and pus at once escaped. The wound had been protected before the peritoneum was opened. Gauze rolls were passed into the loins and the left side of the pelvis to absorb the pus during the next stage. The appendix was sought and found embedded in soft adhesions. Its mesentery was clamped, divided, and ligatured with cat-gut. The base of the appendix was crushed by means of powerful Spencer Wells forceps. A purse-string sero-muscular cat-gut suture was inserted in the cæcum around the root of the appendix, and a quarter of an inch away from it. The appendix was divided through the crushed and sealed base, which was invaginated by tying the purse-string suture. All the pus was carefully mopped away from the pelvis and the flanks with moist gauze. Care was taken not to allow the bowels to protrude. The upper part of the wound was then closed in layers, and a short tube was placed in the lower angle of the wound. This tube was only just long enough to reach into the abdominal cavity, and it contained a wick of gauze. Sutures were placed in the lower part of the wound ready to be tied later. An injection of morphia, one quarter grain, was given immediately after the operation, and saline enemata were given regularly through the night. Only water was given by the mouth for twelve hours, and then milk diluted and flavoured in various ways was given. No purgative was given. An enema acted well on the third day. The semi-sitting position was adopted from the first. The tube was removed on the third day, and the wound rapidly healed.

Remarks. — From a study of the detailed clinical history and the appearances at the operation, it is clear that the appendix had perforated early in the attack, and that a localised abscess had formed, and that this, increasing in size, had ruptured on its left aspect, discharging its contents into the pelvis and general peritoneal cavity. It is a great pity that the patient was not sent in earlier, because it is now well established that it is far better to operate upon these patients within the first few hours of the illness before suppuration develops. Mr. Mutch has recently collected all the cases treated at Guy's Hospital in recent years, and finds that all the patients operated upon within twenty-four hours of the onset of the attack recovered, whereas the general mortality is about 20 per cent. Moreover, by early operation the risk of peritonitis and other complications is greatly diminished; and this is especially true of the risk of intestinal obstruction. In dealing with these late and infective cases it is of great importance to complete the operation as rapidly as possible. The whole operation can be done in less than twenty minutes in these cases of general peritonitis in which the adhesions are generally soft, so that there is no great difficulty in removing the appendix. I remove the appendix in all cases, and thus lessen the risk of complications and recurrence. It is well known from the statistics brought before the Royal Medico-Chirurgical Society that recurrence takes place in about 15 per cent. of the cases treated without removing the appendix. It is very important not to expose the bowels unnecessarily, for this leads to distension and adds to the length of the operation. In many of these late cases in females I close up the abdominal wound entirely and drain only by the vagina; but in this case the peritonitis seemed to me to be too extensive and grave for this. Silk is to be avoided as a suture material for the abdominal wall, which is of necessity likely to be infected. The peritoneum is approximated with strong cat-gut and the remainder with strong salmon-gut sutures, which are not removed for a week or ten days. I hold very strongly that it is a dangerous thing to try to purge these patients either by means of an injection of saline purgative into the bowel at the operation or by the administration of drugs by the mouth during the next three or four days. It is far better to let the bowels be at rest and to give the patient one or more injections of morphia after the operation. The bowels often open naturally or too freely on the third or fourth day, but if they fail to do so, or if there be much distension, a simple soap or a turpentine enema gives relief. I am convinced that attempts at purgation are the surest means of increasing paralytic distension of the ileum. The patients have rarely taken any food, except slops, for several days before the operation, and there is no need to empty the bowel. Much of the improvement of the results of recent operations is no doubt due to the recognition of this fact, to the adoption of the

semi-sitting position of Fowler, to the recognition of the value of rapid as well as accurate work, and through the administration of water by the mouth, or saline by the rectum or into the cellular tissues. I feel sure that it is most unnecessary and vicious to pass either tubes or gauze far and wide into the abdomen amongst the coils of the intestine. All that is necessary for drainage purposes is to insert a tube containing a wick of gauze just under the parietal peritoneum. This plan lessens the risk of death, fistula, and intestinal obstruction. It is only necessary to drain the peritoneum in the very late cases. It is a great mistake to close up the abdominal wound without any provision for drainage, for under these circumstances cellulitis may develop in the abdominal wall, and may lead to death in some cases. I therefore always pass a wick of gauze as far as the outer side of the parietal peritoneum in all these late cases. This does not in any way lead to weakness of the abdominal wall, for the sutures can be tied on the second or third day.

Dental Notes.

LOCAL INJECTIONS.

IT is interesting to note the increasing popularity of the use of local anæsthetics for the painless extraction of teeth.

During the year 1909, about twelve hundred local injections were given for the removal of teeth in Guy's Hospital Dental Department.

Some discrimination in the selection of the patients is exercised; that is to say, those persons alone are recommended for injection whose gums and mouth are in a healthy condition.

Extensive sloughing of the tissues is liable to occur when inflammation of the gums, or acute or chronic suppuration, exists in the mouth.

If the extraction of one tooth only is required, a tablet of the drug, Novocaine or Cocaine, is dissolved in thirty minims of water, previously boiled and allowed to cool.

A strong all-metal syringe, with a new needle for each patient, is used, and the syringe and needle are, before each injection, sterilized by boiling.

The solution is injected into the gum overlying each root of the tooth, *e.g.*, one puncture over each of the buccal and another over the palatal root of an upper molar.

A stronger solution of the drug, consisting of two tablets in 40 minims of water, is used, if it is required to extract two adjoining teeth, and the injection is made between these teeth.

In no instance has any untoward general symptom arisen, but three patients returned complaining of pain in the sockets of the extracted teeth, which condition was relieved by free syringing with an antiseptic for two or three days.

No doubt a larger percentage of tooth-sockets became septic, but there are no notes of other patients coming for after-treatment.

The success and safety of local injections for the painless extraction of teeth indicate that the procedure is being more and more appreciated by the public, who seem to regard it as an easy way out of a painful operation.

A Case of Perforating Wound of the Cornea, with an unusual accompaniment.

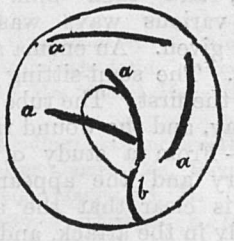
By T. E. ASHDOWN CARR, M B., B.S. (Lond.),
Resident Surgical Officer to the Birmingham and Midland Eye Hospital.

A. A., æt. 18, a boiler maker, was admitted into the Birmingham and Midland Eye Hospital at mid-day on January 1st, 1910.

History.—At 3.30 p.m. on the previous day he had been punching out a rivet, of which the "counter-sink" (a circular piece of iron, about $\frac{7}{8}$ inch in diameter and $\frac{3}{8}$ inch thick, with sharp edges) had flown upwards and struck his left eye.

Condition.—There was a perforating wound in the lower part of the cornea, almost vertical in direction and about $\frac{1}{4}$ inch in length, through which an œdematous piece of iris was prolapsed, the pupil being thus drawn somewhat in the direction of the wound. The ocular tension was greatly diminished and the anterior chamber was practically obliterated. As much of the lens as could be seen was swollen-looking and opaque.

In the anterior chamber four black hair-like structures were seen: one was placed across the centre of the lens, another along the margin of the iris, and two others could be seen lying on the front of the iris (vide figure).



a a a a Four apparent cilia.
b Position of corneal wound (and prolapse of iris).

These turned out to be, as was supposed, some of the patient's eyelashes: some of the apparently single cilia proved to be really groups of two or three, and as a

matter of fact seven lashes were removed with iris forceps. The prolapsed portion of iris was excised.

Examination with the Haab magnet was negative: an X-ray photograph was not obtained.

Examination of the cilia: These were all about half an inch long, and in general character and size conformed rather to the lashes of the patient's upper lid than of the lower; with a single exception, all had the hair-root attached. There was not the slightest scratch or abrasion anywhere to be found marking the patient's lids, even when examined with a hand lens, nor was any particular spot discovered suggesting that the cilia had been withdrawn therefrom.

Unfortunately the eye did badly, and on January 8th it was deemed advisable to excise it. When examined after removal, the lens showed commencing absorption, and the ciliary processes were rather prominent, but the vitreous was perfectly clear, without any sign of commencing suppuration, and the most careful examination failed to show the presence of any foreign body.

Remarks.—Although the presence of cilia in the anterior chamber as a complication of a perforating wound of the cornea is not remarkably rare (Parsons in his Pathology of the Eye, vol. iv., gives a list of the literature on the subject), yet it is not a condition very often met with, and the case reported above presents one or two features which I think must be rather unusual, viz., the intact condition of the lids, and the distance from the corneal wound at which some of the hairs were lying in the anterior chamber.

The first point would seem to be most satisfactorily explained by assuming that the "counter-sink" flew off with such considerable velocity as to give it sufficient momentum not only to tear out by the roots some of the lashes, as the patient made an involuntary blinking movement, but also to carry them through the opening made in the cornea.

How some of the cilia came to be lying high up on the iris is difficult to understand; they can hardly have been carried there by any current of fluid making its way towards the filtration angle, for even in the normal eye "there is no question of a flow or current of fluid through the anterior chamber" (Parsons, vol. iii., p. 967), and Fuchs points out that when there is an escape of æqueous from the anterior chamber, although its regeneration is greatly accelerated, the normal ocular outflow is diminished. (Text-book of Ophthalmology, English translation, 1908, p. 297.) On the other hand, it must be remembered that twenty hours had elapsed between the accident and the time when the patient came under observation, during which time, owing to various ocular movements, the cilia in the anterior chamber must have undergone varying degrees of pressure between cornea and iris, and the irregularities of the surfaces of cilia and iris may have quite possibly been sufficient to cause the change of position of the former upon the latter.

I should like to conclude by thanking Mr. Jameson Evans, Hon. Surgeon to the Hospital, for kindly giving me permission to publish an account of the case.

Pass List.

University of Cambridge.

EXAMINATION FOR DIPLOMA IN TROPICAL MEDICINE AND HYGIENE.

E. P. Minett.

Final Conjoint Examination, Jan., 1910.

MEDICINE AND SURGERY.

*F. S. Adams, *J. W. Williams.

SURGERY AND MIDWIFERY.

*H. G. Rice, *J. G. Saner, T. D. M. Stout.

MEDICINE ONLY.

W. T. Clarke, F. Kahlenberg, *T. J. Killard-Leavey, Q. H. Richardson, *V. T. P. Webster.

SURGERY ONLY.

N. L. M. Reader, C. C. Tudge, *C. Weller.

MIDWIFERY ONLY.

*W. H. Catto, G. Dunderdale, J. A. Edmond, W. H. Talfourd Jones, K. T. Khong, G. Maxted, R. G. Oram, J. Pryce-Davies, W. Reynolds, F. D. Saner, A. L. Saul.

* Denotes completion of examination.

Second Conjoint Examination.

ANATOMY AND PHYSIOLOGY.

K. B. Clarke, E. C. Cline, A. B. Danby, H. C. Godding, F. C. Hunôt, E. L. Jones, A. G. H. Moore, A. Tilbury.

First Conjoint Examination.

Parts I. and II.—CHEMISTRY AND PHYSICS.

W. A. Easton, C. de W. Gibb, V. E. Lloyd.

Part I.—CHEMISTRY.

C. R. Smith, W. H. A. D. Sutton.

Part III.—ELEMENTARY BIOLOGY.

H. Parry Price, T. R. Trounce.

Part IV.—PRACTICAL PHARMACY.

J. E. Davies, H. W. Doll, F. C. Godding, E. M. Mahon, W. L. Partridge, E. C. Peers, A. F. Salsbury, F. D. Saner, O. E. Williams.

Preliminary Science (L.D.S.) Examination.

Part I.—CHEMISTRY. Part II.—PHYSICS.

E. L. Fraser, C. D. Neale, C. J. Phillips.

CHEMISTRY ONLY.

S. W. Bevis, E. R. Williams.

PHYSICS ONLY.

E. R. Saul.

Two Cases of Urgent Dyspnoea in Children.

BY DR. MANN.

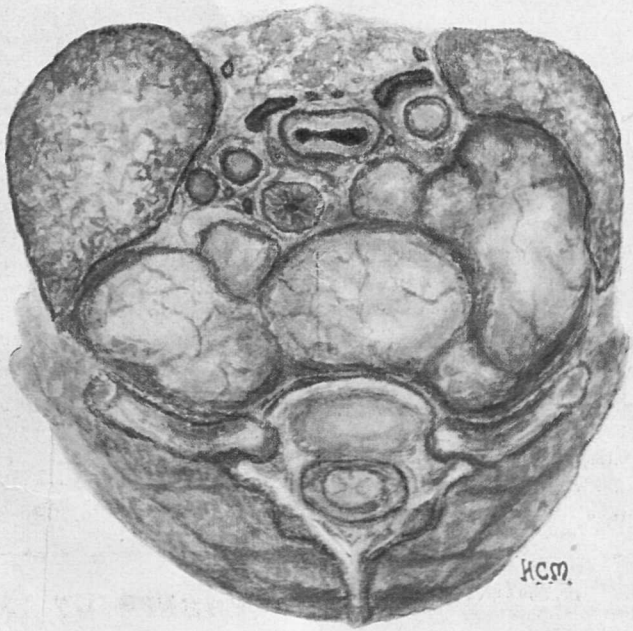
AMONG diseases of childhood there are none which are so frequently a cause of alarm to the parent, or a source of difficulty in diagnosis and treatment to the medical man, as those giving rise to dyspnœa. In both the cases here published the trouble was due to tuberculous mediastinitis, from which spinal caries developed. These are not examples of laryngeal spasm, reflexly due to pressure of enlarged glands upon intra-thoracic nerve trunks or their branches, but cases of bronchial or tracheal obstruction. In both cases there were signs of obstruction to the superior vena cava, the cervical veins were engorged, the face œdematous and cyanosed, the voice unaltered in character or intensity.

The first case was under my care in the Evelina Hospital, and to Mr. H. D. Wyatt, my house physician at the time, I am indebted for the notes. The second case I was asked to see, unofficially, by Sir Cooper Perry's house physician, and with the first case in one's mind the diagnosis of the condition presented no difficulty. The excellent report is by Mr. Mutch, and Sir Cooper Perry has kindly permitted me to publish the case and to utilize the specimen which I have dissected and mounted for the Guy's Museum.

CASE 1.—E. M., a boy aged eight, was brought up to "out-patients" at the Evelina Hospital on July 8th, 1907, for attacks of breathlessness. On inquiry from the parents it was found that for some two years past he had been liable to attacks of bronchitis, but previously to that had been quite a healthy well-developed child. About the end of May, 1907, it was first noticed that he was wasting and liable to attacks of dyspnœa at night, at first only slight, with cough and a little expectoration, latterly accompanied by congestion of the face and stridulous breathing. On examination, there was found some impairment of entry into the right upper lobe with a good many moist sounds in this part of the chest. It was thought that the condition might possibly be due to fibrosis of the lung with some local bronchiectatic change. He was again brought up on July 25th with a story of the attacks having increased in severity, accompanied by pain in the chest. It was noticed that there was deficient movement of the upper part of the right chest, deficient entry of air with a slight stridor heard all over the right side. On percussion, a dull note was obtained in the first and second intercostal spaces near the sternum on the right and to a less degree on the left. The upper part of the sternum also gave a dull note on percussion. The neck was noticed to be swollen, with enlarged veins visible in front over the clavicles and lower part of the neck. The episternal notch was obliterated. The thyroid gland seemed to be somewhat enlarged. A good view was obtained of the larynx, and nothing abnormal was detected. It was noted that the stridor was markedly increased when the head was flexed towards the sternum, and the boy complained of pain in the chest when in this position. He had no pain in the back, and the cervical spine appeared normal. One or two glands below the angle of the mandible were somewhat enlarged on the right side; there was no sign of a retropharyngeal abscess. Owing to the rapid increase in the severity of the symptoms, a diagnosis of mediastinal growth was made, probably originating in the thymus. The accompanying skiagraph (Fig. 2, case 1) shows very well the diminished transradiancy in the upper part of the thorax, as observed at that time. During the course of the next fortnight the symptoms increased in severity; the face was very œdematous, the superficial veins were tortuous and enlarged, his attacks of dyspnœa were very urgent, and the pain very severe. On two occasions the boy actually stopped breathing, and the house-physician was about to perform tracheotomy, and push a catheter down through the bronchus. However, he recovered from the attacks, and by August 16th, though the stridor persisted, the pain was much better. At no time did he lose his voice, nor was there any alteration in it. The temperature chart now showed an evening rise to 101° F. The face was still œdematous and cyanosed. On August 24th his gait was noticed to be peculiar, the knee-jerks brisk, with ankle clonus on the right side. The attacks of dyspnœa were now less urgent. On August 30th he first complained of pain in the back, and tenderness was found over the last cervical and upper two dorsal vertebræ; there was, as yet, no deformity. By the end of September a kyphosis involved the last cervical and the upper three dorsal vertebræ. The further progress of the case was uneventful. He was kept on his back for four months, and then fitted with a poro-plastic jacket and jury mast, which apparatus was employed until July, 1909. For the last six months he has discontinued the use of it. There is no evidence of

Two Cases of Urgent Dyspnoea in Children.

By Dr. MANN.



Case 2, Fig. 3.

EXPLANATION OF SKETCH.

The sketch shows the second dorsal vertebra, viewed from above. Immediately in front of the body of the vertebra is seen the abscess which is in communication with the carious third dorsal vertebra and spinal canal. Laterally are seen the caseous masses formed of breaking-down mediastinal glands, compressing on the right side the upper lobe of the right lung. The œsophagus is displaced forwards and to the left, lying behind and to the right of the left common carotid and subclavian arteries, the vagus intervening. The trachea is pushed forwards, adherent to surrounding mediastinal tissue; the innominate veins compressed by inflammatory tissue are on either side in front, and the innominate artery lies to the right of the trachea. The anterior part of the mediastinum is filled with caseous mediastinal tissue.

The sketch is reproduced the same size as the specimen.

active disease, and he is developing normally. From the time spinal trouble became apparent his pain diminished, and the attacks of dyspnœa were less frequent. The stridor was still heard on both sides of the chest as late as in May, 1908, and eventually this sign disappeared. The photograph of the boy was taken in November, 1907. (Fig. 1.)

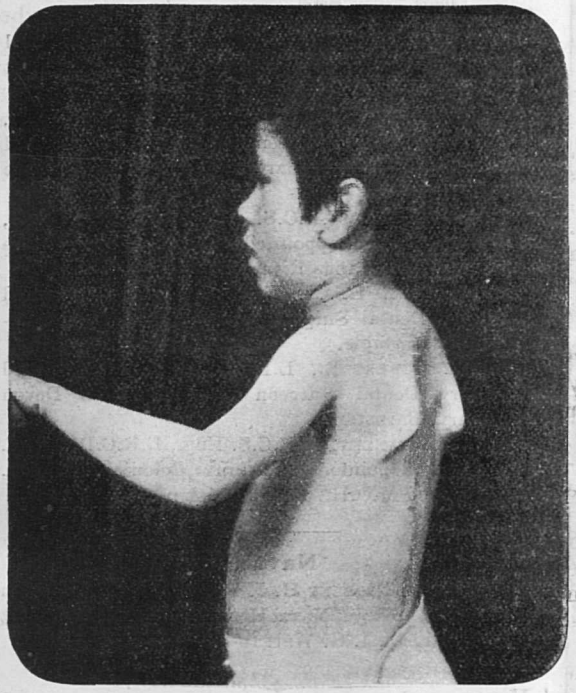


Fig. 1.

Case 2.—J. B., a boy of 3 years, was admitted into Stephen under Sir Cooper Perry, on November 27th, 1909, for attacks of urgent dyspnœa. The boy was sent up from the Brook Fever Hospital with the following history:—

"On August 21st, 1909, he was admitted to the Brook Hospital with diphtheria; shortly afterwards he developed whooping-cough, and on September 23rd scarlatina followed. As a complication he had a left-sided otorrhœa, which ceased on November 15th. He had by this time almost completely recovered, when he developed pain in the back. This rapidly became more marked. A diagnosis of spinal caries was made and complete paraplegia quickly developed. On November 22nd he had an attack of dyspnœa with stridor and costal recession, lasting about half an hour. The voice was quite clear. Nothing could be seen or felt in the throat. There was no difficulty in swallowing. Two swabs taken recently from the nose and throat showed no evidence of the presence of diphtheritic organisms. The child has not been in contact with other infectious cases since September 13th. Desquamation was completed by November 7th. During his stay in the Brook Hospital he has been kept in bed."

During the five days before the boy's admission to Guy's the breathing became gradually more laboured, and there were in all four attacks of urgent dyspnœa, respirations during the intervals being of a "wheezy" type.

When I saw the child on the afternoon of November 28th, he was just recovering from an attack, the third since admission some eighteen hours previously. The superficial veins in the neck were then engorged with blood, the face was pale and œdematous, the lips cyanosed. There was sucking in of the lower three intercostal spaces, the diaphragm and the upper part of the chest being in action. A loud stridor, inspiratory and expiratory, was heard all over the chest, though more marked over the right lung. The child was talking to Sister, and asking for drink. On percussion there was a dull note over the upper part of the sternum, and an impaired note over the upper two intercostal spaces near the sternum. The heart appeared to be working efficiently, action rapid. The knee-jerks were absent, the lower limbs paralysed, and there was loss of sensation below the umbilicus. During the next eighteen hours there were further attacks of dyspnœa, and after one of these the child stopped breathing. Tracheotomy was performed by the house physician, Mr. C. M. Plumptre, and a catheter passed down into the bronchus, but the child was dead.

At the autopsy.—Dr. Hertz found miliary tubercles in the spleen and liver, and a few tuberculous ulcers in the small bowel. I removed, with his permission, the thoracic viscera with the upper dorsal vertebræ *en bloc* (Fig. 3). The trachea was pushed forwards by a large mediastinal abscess which surrounded the œsophagus, and was densely matted to surrounding structures, the remains of the thymus being involved in an abscess of the anterior mediastinum. This mass of inflammatory tissue flattened the trachea antero-posteriorly, and obstructed the innominate veins and the superior vena-cava. The bronchi were matted to the adjoining pulmonary vessels and cellular tissue,

the mucosa of the lower part of the trachea and bronchi was œdematous and congested, the larger tubes containing sanguineous but not purulent secretion. There was no evidence of rupture into either bronchi or trachea, these structures being surrounded by a multilocular abscess cavity evidently formed of breaking-down mediastinal glands, and not in communication with the abscess in the posterior mediastinum, which opens into the spinal canal through the remains of the body of the third dorsal vertebra. The second, third, and fourth dorsal vertebræ are all extensively involved with tuberculous caries, and the spine partially dislocated. The spinal cord was surrounded, especially on its anterior aspect, with granulomatous material. It was interesting to notice that the bronchial glands at the bifurcation of the trachea were hard and calcareous, suggesting that this was the original focus of tuberculous disease, and that from here disease had spread to the mediastina and the spine. The œdematous mucosa, the flattening of the lower end of the trachea, and the compression of the bronchi by the surrounding inflammatory material, explain the loud double stridor heard over the chest. The larynx and all other viscera appeared normal on examination.

Mr. H. Stott recently described in the columns of the Gazette a fatal case of bronchial obstruction due to rupture of a tuberculous gland into the bronchus, but I have not read of the association of paroxysmal respiratory obstruction with tuberculous mediastinitis and caries, so that I think these two cases may well be recorded.

Change of Address.

Fleet Surgeon Robley H. J. Browne, R.N., from H.M.S. *Téméraire*, to Royal Marine Barracks, Shotley, Harwich.

Graham Hunt, L.D.S. Eng., from Percy Lodge, Torquay, to Ardross, Vicarage Road, Chelston, Torquay.

J. R. Palmer, L.D.S. Eng., from 153, Dock Street, Newport, Mon., to H.M.S. *Ganges II.*, Shotley, Harwich.

Lieutenant M. A. Rahman, I.M.S., from Aldershot to c/o Messrs. Grindlay, Groom & Co., Bombay, India.

H. Gordon Spain, L.D.S. Eng., from Guy's Hospital to Marine Infirmary, Royal Marine Barracks, Deal.

H. Stanley Turner, M.R.C.S. Eng., L.R.C.P. Lond., from 20, Putney Hill, S.W., to West Falkland, Falkland Islands, South Atlantic.

J. W. Williams, M.R.C.S. Eng., L.R.C.P. Lond., L.S.A. from Guy's Hospital to Graig Villa, Pontypridd.

(The Editor will be very glad to receive a postcard with notes of any change of address.)

Appointments.

University of Oxford.

Dr. Walter Ramsden, Fellow of Pembroke, has been appointed by the Waynflete Professor of Physiology one of his Demonstrators for three years.

Civil.

Bowes, J. Arnold, L.D.S., has been appointed Dental Surgeon to the Metropolitan Ear, Nose, and Throat Hospital.

Mayer, Clifford, M.D., B.S.Lond., M.R.C.S., L.R.C.P., D.T.M.&H. Camb., has been appointed Chief Medical Officer to the State of Baroda, and Physician to the Gaekwar.

Pakes, W. C. C., M.R.C.S. Eng., L.R.C.P. Lond., D.P.H., has been appointed Medical Officer to the Leper Asylum, Orange River Colony, South Africa.

Pearce, H. G., L.D.S. Eng., has been appointed Honorary Dental Surgeon to the North Devon Infirmary, Barnstaple.

Shapland, Hubert R., L.D.S., has been appointed Honorary Dental Surgeon to the North Devon Infirmary, Barnstaple.

Turner, H. Stanley, M.R.C.S. Eng., L.R.C.P. Lond., has been appointed Assistant Colonial Surgeon, Coroner, and M.O.H., Falkland Islands.

Naval.

Fleet Surgeon Robley H. J. Browne, R.N., has been appointed to the Royal Naval Hospital, Shotley, Harwich, and Staff Surgeon J. G. Watt to the *Sutlej*.

Papers by Guy's Men.

Major G. Travers Birdwood, M.D., I.M.S. Smith's Operation of Extraction of the Lens in its Capsule.—*The Indian Medical Gazette*, January, 1910.

H. Chapple, M.B., B.C. Camb., M.R.C.S. Eng. The Treatment of Cases of Fracture of the Femur after Operation (Illustrated).—*The Practitioner*, February, 1910.

A. Alan Forty, L.D.S. Eng. Case of Immediate Torsion (Illustrated).—*British Dental Journal*, 15th January, 1910.

W. Ilbert Hancock, F.R.C.S. Eng. Three Cases of Post-Operative Infection.—*Royal London Ophthalmic Hospital Reports*, January, 1910.

Montagu F. Hopson, L.D.S. Eng., F.L.S. A Review of some Modern Theories of Variation and Heredity, and some Suggestions as to their Application to the Study of Orthodontia.—*The Dental Record*, January, 1910.

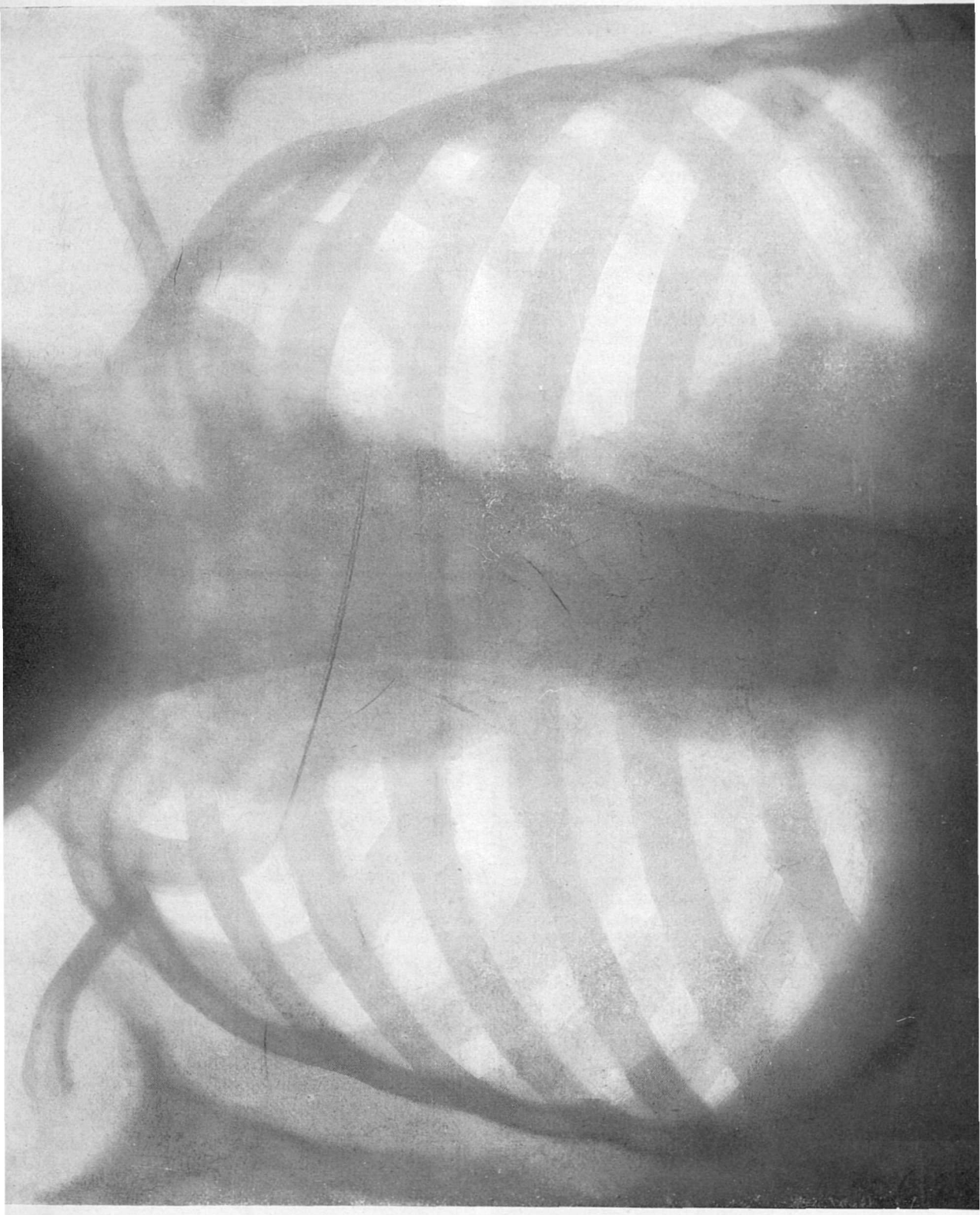


Fig. 2. Skiagraph of Chest (Case 1.)

Two Cases of Urgent Dyspnoea in Children.

Some Minor Throat Affections of Adults.

CLINICAL LECTURE BY MR. STEWARD.

Gentlemen,—As your success in practice depends to a considerable extent upon your ability to deal successfully with minor ailments, and as minor affections of the throat form a large proportion of minor affections generally, I propose to speak to-day of some of the affections of the throat met with in everyday general practice.

1. *Acute pharyngitis.*—This is a very common form of sore throat, and is an acute infective process, most commonly mild in degree, and forming a part of an ordinary cold, but sometimes much more severe, and due to infection spreading from carious teeth, or some other focus in the mouth, or to a streptococcal infection of a wound or abrasion in the throat.

The patient is usually decidedly ill, with temperature and pulse raised, and complains of great pain in the throat and back of the neck, especially on attempting to swallow. Inspection shows a varying degree of redness and swelling, according to the severity of the infection, and affecting chiefly the pharynx, and, to a less extent, the fauces, tonsils, and soft palate. Frequently also the mucous membrane is covered with a layer of thick tenacious mucus, and the patient suffers much pain from his efforts to rid himself of this.

As regards treatment, it is well to start with a purge, especially if, as often is the case, the patient is an alcoholic. These cases of pharyngitis are sometimes looked upon as gouty, but I am inclined to think that the predisposing condition is much more frequently alcoholism than gout.

Unless the case is a very mild one, the patient is better confined to bed, and a warm fomentation should be applied to the throat. This often produces marked relief.

Locally, the best application in severe cases, especially where tenacious secretion is a marked feature, is an alkaline spray containing 20 gr. each of bicarbonate of soda and borax to the ounce of water. A spray is the only satisfactory method of application, because gargling is inefficient, and sucking pastilles and painting are both much too painful.

In the milder cases, and after the more acute symptoms have subsided, a mild astringent spray is very useful, as is also the application of an antiseptic. The best method of applying an antiseptic to the throat is to suck one of the forms of lozenge made of formalin and lactose, the solution in the saliva forming a strongly antiseptic and yet unirritating fluid. If swallowing is not too painful, and the patient will persevere with these tablets, they undoubtedly are most efficacious in rapidly clearing up all the varieties of infective inflammation of the pharynx and tonsils.

2. *Acute pharyngeal myositis.*—It is not at all uncommon to meet with cases of acute sore throat in which little or nothing abnormal can be detected on examination. The patient feels ill and complains of great pain in the throat and neck on swallowing. On going into the history you will often find that these attacks are recurrent, and that the patient describes himself as "rheumatic," possibly not in the true sense, but the type of patient who has lumbago, and gets stiff shoulders easily from getting damp. I believe these sore throats are due to myositis of the pharyngeal and faucial muscles; that is why so little is seen on examination, and yet all movements of these muscles are so painful.

The best treatment is undoubtedly to give aspirin, a 20 gr. dose to commence with, followed by small regular doses. Improvement is very rapid, and often the pain almost goes a few hours after the first dose. In one case I saw, the patient had practically starved for three days because swallowing was so painful, and yet after a couple of doses of aspirin he was practically well.

3. *Chronic pharyngitis.*—Now let us consider the more chronic groups of cases. First, the ordinary chronic pharyngitis. A large number of people have this. They come saying they have got a "throat," and their symptoms are rather vague. They say they have no pain in swallowing, and their discomforts are rather between meals than during meals. Some say their throats get dry sometimes; others, that the throat is hot; others that the throat is uncomfortable, particularly in the morning, and that they have to hawk and spit out greyish or blackish mucus, according to the atmosphere they live in and whether it is foggy or not. The symptoms are a great trouble to the patients. Some think they have a swelling there; and others worry because they are in fear of cancer. The throat varies with the general condition, and is always worse when the patient is run down, or overworked, and this explains the dread of cancer of the throat so often met with in people who have nursed a near relative suffering from

malignant disease. The condition is also common in those who use the voice, more particularly in teachers, speakers, and clergymen, and hence the name "clergyman's sore throat."

In nearly all these cases there is a predisposing cause at work, and that is *nasal obstruction*, the overwork, or ill-health, or excessive use of the voice being the exciting cause.

The nasal obstruction is often quite slight in degree, and the patient may even be quite unaware of it. He may say that he can breathe through the nose quite comfortably, but nevertheless admits that he always wakes with a dry mouth and throat, so that he undoubtedly sleeps with his mouth open.

When you remember that the passage of air through the nose results in its being filtered, warmed, and moistened, it becomes quite obvious that the breathing all night through of air too cold and too dry, and full of dust and micro-organisms, is quite sufficient to account for the production of pharyngitis. The appearances on examination vary a good deal. In some only a little abnormal redness, and undue prominence of vessels is seen, in others the lymphoid follicles are red and prominent—the so-called granular pharyngitis; and in others again a thickened prominent band is seen just behind the posterior faucial pillar on each side—the lateral hypertrophic pharyngitis.

The treatment consists, in the first place, in removing the predisposing cause—the nasal obstruction. This may be, of course, due to many causes, and it would take much too long to go into them and their treatment now. Locally, treatment will also be necessary, mild astringent and stimulating applications being most useful, either in the form of paints or lozenges or both. Of paints I think Mandl's solution—Iodine, grs. v., Pot. Iod. grs. x., Ol. Menth. pip. ℥v., Glycerine ad ℥i.—the best, and of lozenges, krameria, menthol and red gum pastilles.

In cases of granular pharyngitis, destruction of the granules, a few at the time, with the electro-cautery will often do much good, and in those of lateral hypertrophic pharyngitis division of the thickened bands with the cautery sometimes completely removes the symptoms when other methods of treatment have failed.

The general health must also be attended to, and where overwork and worry are prominent factors a holiday will, of course, do more good than anything else. Finally, you must bear in mind that in voice users wrong methods of voice production often help to aggravate pharyngitis and will need correction.

4. *Pharyngitis sicca.*—This is quite distinc from the ordinary chronic pharyngitis. The patient complains of constant dryness of his throat, and of coughing up dry hard crusts. When you look at the throat you find that the mucous membrane is dry, and plastered over with a dry layer of mucus, sometimes forming a crust, which you can peel off. This is an atrophic condition, and is always associated with similar disease in the naso-pharynx, or nose, or both, viz., the condition of atrophic rhinitis. There is atrophy of the mucous membrane, and especially of the inferior turbinates, and covering the mucous membrane are green, grey, or yellow crusts. With regard to treatment, this is the same as for atrophic rhinitis. Use an alkaline solution to spray or gargle, to remove the crusts, or use a weaker solution, as for the nose. For the nose use common salt, 1 dr., sodium bicarbonate, 1 dr., 1 in 20 carbolic ½ oz., to warm water a pint. Direct the patient to douche the nose with a pint of it morning and evening, and use a little of it to gargle the throat out at the same time. Painting with Mandl's iodine paint is also very useful for this condition. Pharyngitis sicca and atrophic rhinitis are very chronic, and usually persist for many years, but the patient will keep comfortable provided that he perseveres regularly with the douche.

5. Another pharyngeal condition is what may be termed *aching* and *tired* throat. A certain number of patients have very much the same symptoms as those of chronic pharyngitis, but they are more vague, except in those two particulars. They tell you their throat aches so much that after talking they can hardly bear it. Often they are people who like to sing, but they get such pain and aching after singing that they have to give it up. The subjects of this condition are usually clergymen and teachers. It frequently happens that their general health is not very robust, and they feel the throat condition more when run down and overworked. Teachers consequently always get worse towards the end of the term. In the throat you find very little wrong, and sometimes the condition is confused with chronic pharyngitis.

The cause of this condition is invariably improper voice production, resulting in undue strain being thrown on the pharyngeal muscles. The trouble may not manifest itself until after years of teaching, but when it does it is extremely troublesome, and usually requires prolonged rest and training in voice production for its cure.

6. *Tonsillitis.*—I have recently lectured upon the various forms of acute tonsillitis, so I will not deal with them to-day, but the condition known as chronic or recurrent tonsillitis is well worthy of attention.

The patient complains of frequently repeated attacks of slight soreness and discomfort in the throat, usually on one side only, and accompanied by foul breath, headache, and slight malaise. After a few days, a mass, sometimes of considerable size, of foul-tasting cheesy material works out of the tonsil, and the attack then passes off.

On examining the tonsil under good illumination with a probe, it will be found that one or more deep pockets are present, and contain more or less of the cheesy material. The tonsil is frequently quite small and flat, so that it cannot be easily removed.

The treatment consists in cocainizing the tonsil and removing the walls of the crypts with punch forceps, so that they are freely open on the surface, and retention can no longer occur.

7. *Catharral laryngitis.*—This is, of course, usually associated with a common cold, and either comes on at the outset, or later spreads downwards from the nose and pharynx. In the great majority of cases it soon passes off, but in others, especially in adults, it persists and at times becomes extremely chronic.

In the acute stages the best treatment, apart from that of the cold, consists in applying a mustard plaster or mustard leaf to the front of the larynx. This, in many cases, is all that is necessary. In the more severe cases steam inhalations and warm moist applications externally seem to afford a good deal of relief, and if, as occasionally happens, there is secondary spasm of the larynx, a few doses of bromide should be given.

Most of these cases are, however, so slight that they are treated at home, and it is only when the condition has persisted for some time that the patient seeks advice. He will come complaining of hoarseness dating from a cold, usually better in the morning, getting worse as the day progresses, and accompanied by more or less painful cough.

On examination, the larynx, as a whole, appears perhaps rather redder than usual, but the chief change is seen in the vocal cords themselves, which are pink or red, and often a little swollen, so that they appear rounded. Now, normally, the cords are white or yellowish-white in colour, and quite sharp and clear cut in outline, so that the appearances I have just mentioned, though slight, are quite distinctive.

In treating such a case, rest is far the most important factor, and if the patient can be got to abstain from speaking above a whisper for a few days he will probably get rapidly well. But if the patient is a busy man, and cannot give up the use of his voice altogether, the condition will be much more difficult to cure. Counter-irritants outside certainly are useful; I suppose they act in the same way as Bier's treatment, causing hyperæmia. But the local treatment is the most important. This consists of applying chloride of zinc solution to the surface of the vocal cords, 20 to 40 grs. to the ounce of water is the best strength. Some say you should apply it with a spray, but that is not satisfactory, because it is a difficult thing to do. The proper way to apply drugs to the surface of the larynx is by means of a brush. If you can do that properly you will probably rapidly cure your patient. You must have a good light, have the patient sitting in front of you, and use your forehead mirror. Instead of going to work as you ordinarily would in examining the larynx, taking the patient's tongue in the left hand, and the laryngeal mirror in the right, you want a free hand, and so you make the patient hold his own tongue, and hold the mirror in your left hand, and the brush containing the solution in your right. It is necessary to apply the solution directly to the cords. Now get the patient to open the glottis by breathing quietly, and then taking a sudden deep breath when you say "Now," and that is when you put the brush in. Of course you place the mirror against the soft palate, and pass the brush by means of its image in the mirror. The manœuvre will seem difficult at first, but the good result obtained will well repay the necessary practice. The application should be made twice a week, or oftener, and may have to be kept up for some time in long-standing cases.

Papers by Guy's Men.

R. D. Mothersole, M.S. Lond., F.R.C.S. Eng. An Operation for Parotid Fistula (Illustrated).—*The Practitioner*, February, 1910.

R. P. Rowlands, M.S. Lond., F.R.C.S. Eng. A Clinical Lecture on when to Operate for Appendicitis.—*British Medical Journal*, 29th January, 1910.

Charles F. Routh, M.D. Lond. Vaccine Treatment of Pyelonephritis in Pregnancy.—*British Medical Journal*, 22nd January, 1910.

Obituary.

William Ilbert Hancock, F.R.C.S.

W. I. HANCOCK, whose death, at the early age of thirty-six, will be keenly felt by a large number of Guy's men, was born at Wiveliscombe, in Somerset, in April, 1873, and was the youngest but one of an athletic family of ten brothers, of whom five gained renown in the football field, and two won their international caps for Rugby Football. Coming of such a family it is small wonder that Hancock himself was an exceptionally fine all-round athlete, and took the prominent place that he did in the athletic world at Guy's.

He joined the hospital in May, 1891, and soon became known as a lawn tennis player of no mean order. He had already won many prizes in the West Country, and had only suffered defeat in the final for the Somerset Challenge Cup. He was captain of the Guy's six in 1892, a year in which the Inter-Hospital Cup was won, and, after playing in every cup tie during four seasons, possessed the remarkable record of never having lost a set in the singles.

Both at cricket and Rugby football his performances were equally remarkable. At cricket he played for his county, and also for Guy's during four seasons, winning the bowling trophy in 1892 with an average of 8·89. In 1894 he did great things as a batsman, getting double figures in every innings but one, and having an average of 41·22.

At Rugby football, again, he represented his county, having won his cap for Somersetshire before he entered Guy's, and but for an injury to his knee would undoubtedly have played for the South. He played regularly for the hospital for four seasons, being captain in 1893–4, and during this period there was probably no finer centre three-quarter playing the game. Possessed of wonderful dodging powers, but running straight, he was able to gain a lot of ground for his side, while in defence his fearless tackling and brilliant kicking often saved his team when hard pressed.

Hancock qualified in 1896, and left Guy's after having taken his F.R.C.S., in 1898. The following year he married Margaret Hay Sweet-Escott. Almost immediately afterwards he turned his attention to ophthalmology, commencing the study at the Royal London Ophthalmic Hospital, to which institution he remained attached during the rest of his life, with the exception of a period of six months, during which he assisted Dr. Richardson Cross, at Clifton. As time went on he obtained various posts at other hospitals, being appointed ophthalmic surgeon to the East London Hospital for Children in 1903, assistant surgeon to the Central London Ophthalmic Hospital in 1904, ophthalmic surgeon to the Bolingbroke Hospital in 1906, and only last year, after ten years' work as clinical assistant, he was appointed assistant surgeon to the Royal London Ophthalmic Hospital, the coveted post of all old Moorfields students. At the Central he was also Pathologist, and the success of the newly-formed school there was in great measure due to his energy as Dean. Wherever he worked, he was recognised as a strong and loyal colleague, a valued member of committee, and an excellent teacher; and was universally beloved by his patients. He was an indefatigable worker, and in addition to all his hospital work he wrote a number of articles on ophthalmic subjects, in all of which he showed marked originality of thought. In addition to being a thorough master of his subject, his chief characteristics were his remarkable clinical instinct, and his operative skill, which was recognised by the best judges as being of an unusually high order, the renowned Professor Fuchs warmly praising him after seeing him operate last summer at Moorfields.

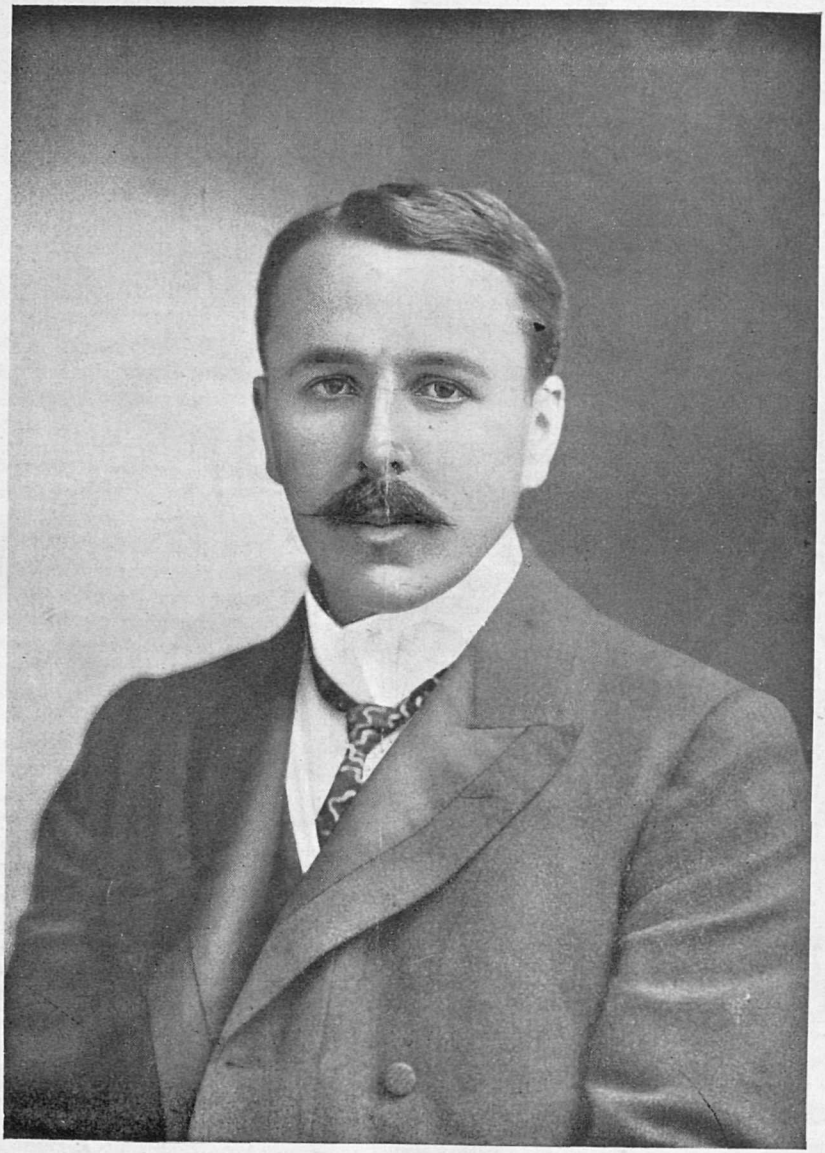
Although Hancock only commenced private practice in 1903, he was doing so well that it is abundantly clear that but for his untimely death he would have attained great eminence in his branch of the profession.

His success was, in fact, far greater than could be accounted for, solely by his high professional attainments, and was no doubt in large measure due to his tact, personal charm of manner, and perhaps in particular to his delightful management of children, which caused his patients not only to believe in him, but to become enthusiastic friends and supporters. It was, indeed, the human side of Hancock that was so attractive, and that so endeared him to those who knew him best; his fearless straightforwardness, his absolute want and hatred of all that was mean, his loyalty to his friends and colleagues, his strength of character and wise judgment which drew so many to seek his advice when placed in circumstances of difficulty, his generosity both to patients and friends; and, finally, his modesty and entire freedom from self-assertion.

Not all who knew him were aware of that undercurrent of active thought and criticism taking place beneath a quiet and deliberate manner, any more than those who watched him walk with almost lethargic ease could guess that he had been one of the fastest three-quarters the Guy's team ever possessed.

But those who were privileged to be his friends could truly say of him he was "a man with a heart, head, hand . . . one who can rule and dare not lie," and for them he leaves a place in their hearts and lives which cannot be filled.

The cause of Hancock's death was pulmonary thrombosis and embolism occurring five days after a perfectly straightforward operation for chronic appendicitis; convalescence from which had, up to this point, been devoid of any untoward symptom. He has left a widow and four children, with whom all who knew him would wish to offer their deepest sympathy.



William Ilbert Hancock, F.R.C.S.

Born 1873. Died 1910.

Notices.

School Examination in Medicine, February, 1910.

The written paper of the School Examination in Medicine for admission to the Revision Classes will be held in the Medical School on Monday, February 14th, at 10 a.m.

The Viva Voce Examination will be held in the Medical School on Tuesday, February 15th, at 4 p.m. Students who wish to attend the Revision Classes in Medicine are required to satisfy the examiners in the above examinations.

The Revision Classes in Medicine will begin on Monday, February 21st, and they will be held in Class Room III., upon Mondays, Wednesdays, and Thursdays, immediately after the post-mortem examinations for the day.

Instruction in Practical Midwifery for Students presenting themselves for the Third M.B. Cambridge, or the Second M.B., B.Ch. Oxford.

Cambridge students who commenced their course of medical study after 1st October, 1907, are reminded that the regulations with reference to evidence of medical study in practical midwifery are as follows:—

1. That before attending the prescribed number of cases (indoor or outdoor) the student has acted as medical ward clerk and surgical dresser, and has attended courses of instruction in midwifery and surgery (lectures and classes).

2. (*a*) *Indoor cases.*—That he has regularly attended for *three months* the indoor practice of a maternity hospital; and that after he has therein received practical instruction in the conduct of labour, and has been approved as competent, he has attended twenty indoor cases of labour under the personal supervision of a medical officer of the hospital; or alternatively—

2. (*b*) *Indoor and outdoor cases.*—That he has been present at not less than ten cases of labour in the wards of a maternity hospital, *or in the maternity wards of a general hospital;* and that after he has therein received practical instruction in the conduct of labour, and been approved as competent, he has attended not less than twenty outdoor cases under the supervision of a medical officer of a hospital, infirmary, maternity charity, or dispensary.

In the case of students at this hospital it will be necessary that each student shall have been present at not less than ten cases of labour in Queen Victoria ward. On application at the Medical School Office a card can be obtained on which the attendance at each of the ten cases must be certified by the member of the Obstetric Staff who conducted the labour. When these cards have been filled up, they should be handed in at the Medical School Office. Students wishing to get signed up for their cases of labour are therefore advised to put their names down on the list in the Porter's Lodge in the College, and every effort will be made to call them when their attendance is required in Queen Victoria ward. Students resident in the College will also be called at night if they will leave instructions with the porter.

Students will also be required to attend the course of demonstrations given by the Obstetric Resident in Queen Victoria ward in the fortnight preceding their month as Extern.

OXFORD STUDENTS.

All students who present themselves for the Second Examination for the Degree of M.B., B.Ch. in Michaelmas, 1910, and afterwards, are required to produce the following certificate:—

> That having previously produced certificates that he has acted as clinical medical clerk and surgical dresser, and a certificate that he has attended a course of instruction in midwifery, the student has either:—
>
> (a.) *regularly attended the indoor practice* of a lying-in hospital, or *the lying-in wards of a general hospital* for a period of three months, and after having received therein practical instruction in the conduct of labour, under the personal supervision of a medical officer, has conducted twenty cases of labour under official medical supervision;
>
> or
>
> (b.) *given daily attendance, during one month, upon the indoor practice* of a lying-in hospital or *the lying-in wards of a general hospital*, and has therein conducted cases under the personal supervision of a medical officer of the hospital, by whom, having been adjudged competent, he has been authorised to attend, and has attended, not less than twenty cases of labour under official medical supervision.

Students who wish to obtain their instruction in practical midwifery at Guy's Hospital will therefore be required to have held the post of obstetric dresser before they can obtain the appointment of Extern.

Royal College of Physicians of London.

CHARLES MURCHISON SCHOLARSHIP IN CLINICAL MEDICINE.

THE next Examination for this Scholarship will be held at the Royal College of Physicians of London on Monday, the 20th day of June, 1910, and following days.

The Examination is open to any Student of Medicine who, subsequently to the date of passing his professional Examination in Anatomy and Physiology for a medical qualification, has studied for a period of not less than two and a half, and not more than five, years at a Medical School in London, recognized by the Royal

College of Physicians, or at the University of Edinburgh, including Medical Classes recognized by the Medical Faculty of the University, whether holding a Medical qualification or not.

The Examination will be conducted both orally and in writing, and will include—

(a) Examination of Patients, with reports on their cases.
(b) Questions on Pathology and Treatment, and
(c) Examination of Specimens.

The Scholarship is of the value of Twenty Guineas, and is tenable for one year.

Intending Candidates are required to send in their names to the Registrar of the Royal College of Physicians, Pall Mall East, London, not later than June 6th, with evidence of the duration of their Medical Studies from the Deans of their respective Schools.

Reviews, etc.

Books for review should be addressed to The Editor, Gazette Office, Guy's Hospital, S.E. Their price should in every case be stated.

Syphilis. By Sir Jonathan Hutchinson, F.R.S. Second Edition. November, 1909. (Cassell & Co., Ltd.)

At the present time, when very great importance is attached to laboratory work, it is refreshing to read a book in which so much emphasis is laid upon the clinical aspects of disease. This monograph on Syphilis, by one of the greatest authorities, is crammed with valuable clinical material. Syphilis, indeed, is a subject which the clinician may justly regard with some little satisfaction. That the many diverse lesions of syphilis scattered over considerable periods of the patient's life have come to be recognised as manifestations of one and the same disease, has been no mean achievement. And the laboratory has been able to add, as yet, but little to our knowledge of the pathology of the disease. The discovery of the Spirochæta Pallida, which is alluded to in the preface to the 1909 edition, only confirms the conclusions upon which great stress was laid in the preface to the 1887 edition, and which had then already been firmly established from clinical data.

In the preface to the new edition is a brief but interesting account of how the author was led to devote himself to the study of syphilis. And, he goes on to say:—

"As I was always a diligent note-taker, it became possible to complete, through more than one generation, many cases which would otherwise have remained fragmentary and comparatively useless. No week passed but some patient whom I had treated many years previously, and quite lost sight of, would turn up again and give me the history of his subsequent life and facts as to his children. My own years having been unusually prolonged, in association with fair powers of memory and mental vigour, I have been able to secure a kind of experience which falls to the lot of but few."

There is a short history of the introduction of syphilis into Spain by the sailors who returned with Christopher Columbus, and of its spread through Europe, as the loathsome camp-follower of campaigning armies. There are also references, chiefly embodied in an appendix, to recent experimental work—the discovery of the Spirochæta Pallida, the Wassermann Reaction, and the treatment by aryl-arsonates. These notes are brief and fragmentary. Atoxyl does not meet with approval.

"Atoxyl contains two energetic poisons, arsenic and aniline. The arsenic often causes polyneuritis, and the aniline optic neuritis. The latter is irrecoverable. . . . It is difficult to find a motive for continued experiments with one [a remedy] so dangerous as atoxyl is admitted to be."

But the main part and the real value of the book resides in its wealth of clinical material. If you wish to know the progress of chancres when mercury is not given, or if you require case-histories of extragenital chancres, or examples of syphilis maligna, if you are curious to know whether congenital syphilis is in any degree protective, or to learn the evidence against the possibility of third generation syphilis—in answer to these and many other interesting matters, you will find apt clinical instances in reply. It is interesting to note that the author regards as an error the statement that the virulence of inherited syphilis diminishes in the younger members of the family. The liability to the disease is less, but, if inherited at all, it is one and the same malady.

There is a valuable chapter on the author's method of treatment. The index seems full and accurate. The illustrations, of course, are excellent.

Papers, etc., Received.

The Etiology of Zymotic Enteritis (Epidemic Diarrhœa). By Ralph Vincent, M.D., M.R.C.P. (Baillière, Tindall and Cox.)

The author's main contention is that epidemic diarrhœa is not an infectious disease in the ordinary sense of the term, and that the putrefactive organisms which are held responsible are "quite unable directly to attack the infant. They are unable to live in the tissues of the living body. Their action is one which is exercised entirely upon the milk, either inside or outside the infant."

Dr. Vincent's practical conclusion is as follows:—"The fundamental characteristic of the natural food of the infant is, that it is a raw fluid. In all circumstances the cooking of milk for the use of infants gravely impairs its nutritive value. With regard to zymotic enteritis, no serious amelioration in the mortality arising from this disease can be anticipated until the fullest protection of pure raw milk is secured for every infant, and special precautions must be taken, at times when heat and dust are prevalent, to secure that the milk for the use of infants shall be preserved fresh and unboiled."

A Visit to Frimley.

A short time ago some of us, on the suggestion of Mr. Lane, paid an extremely interesting and instructive visit to Dr. Paterson, at the Brompton Hospital Sanatorium at Frimley. There phthisis is being treated on a new and strictly rational plan, and the results so far have been very encouraging. The basis of the treatment is essentially a gradual and regulated auto-inoculation. Dr. Paterson regards the disease as one which has a local lesion in the lungs, and produces its constitutional effects by auto-intoxication with the toxins produced at the local lesion, and his treatment is based upon a regulation of the amount of toxin which is allowed to reach the general circulation, such as to produce a gradually increasing degree of immunity in the patient.

He divides phthisical patients into four large groups: (1) Those who have the disease without ever becoming aware of it; (2) Those who will recover with a simple rest, *e.g.*, a stay at the seaside; (3) Those who need to have their process of auto-inoculation regulated; and (4) Those who become rapidly ill and die. His treatment is intended, in the first place, for those in the third group, but, since those of the second group cannot be recognised before treatment by physical signs or other means, it must be applied to them also.

The first step in the treatment is to get the amount of auto-inoculation which is taking place under complete control by means of absolute rest. This consists in keeping the patient in a state similar to that in which one with typhoid fever is kept, and in stopping his cough.

Dr. Paterson distinguishes two kinds of cough in phthisis: the useful or expectorant cough, and the useless or bronchitic cough, and it is the latter alone which should be controlled. This is best done by the free administration of morphia or its preparations.

Observations on the opsonic index have shown that the temperature is an accurate guide to the amount of toxin which is being put into circulation, and we saw most interesting charts showing how a patient on absolute rest, but with a bronchitic cough, had a pyrexia which disappeared at once when the cough was controlled by morphia. When the amount of auto-inoculation has been reduced to the smallest possible amount by absolute rest, the patient is put through a series of exercises of graduated severity. During exercise there is an increased blood-flow through the lungs, and so a larger amount of toxin is put into circulation and a higher degree of immunity is produced. The exercise at first consists merely in allowing the patient to wash himself, and by a series of grades this is increased until he walks half a mile a day. If no ill-effects follow, this is soon doubled until 6 miles a day is reached. The next grade is to carry small baskets of gravel, and the more severe stages are pushing barrows, digging mould, and excavating in a gravel pit.

Bacteriological experiment has proved that any too sudden increase in the amount of circulating toxin produces constitutional effects, evidenced by pyrexia and headache. Therefore, if during the course of the treatment a temperature of 99° F., or over, is reached, accompanied by headache, the patient is at once confined to bed on absolute rest until these symptoms have disappeared, and is then returned by gradually increased exercise, extending over about two weeks, to the grade of work at which he was when the symptoms developed. It is generally found that one such overdose of toxin immunises the patient against the auto-inoculation produced by that particular grade of work.

If the treatment is successful, such a condition of immunity is produced that the patient can withstand any degree of auto-inoculation which he is able to produce; also he is free from constitutional symptoms, and is able to repair the local lesion in his lungs, as is evidenced by the rapid diminution in the amount of sputum coughed up.

The principles underlying the treatment are explained to the patients at Frimley, and they give their ready co-operation in its carrying out. The work which they do is turned to useful account, and practically the whole working of the place is done by the patients themselves, some of whom are treated free, while others pay the nominal sum of twenty-five shillings a week.

Dr. Paterson drew our attention to the unsuitability of the cases usually sent to Sanatoria. The so-called "early cases," who come under treatment very early in the course of the disease, are generally considered the most suitable, whereas they are, in reality, persons with a very low power of resistance, who are unable to withstand even a small amount of toxin.

The cases most amenable to treatment are those who have withstood the disease for a long time, and who come under treatment as the result of an excessive intoxication, or with purely local symptoms.

Dr. Paterson was most kind in showing and explaining everything to us, and we owe him our thanks for a most enjoyable visit.

E. G. S.

A Pro.'s Experience.

Dear Mr. Editor,

Thinking it might interest some of your readers, I have been asked to write an account of an experience I had not so very long ago. I had only been a few months in a small hospital, not so far from you, became a "Pro." there, and had just got my uniform. I had promised the family circle to let them see me in it, and for that purpose took a car from St. George's Church to Streatham one Sunday night. I sat down in a corner, too tired to even look at anyone after having been on duty all day. Doubtless my fellow "pro.'s" know that feeling well. We had not gone far when the car stopped to take up passengers. It being, as I said, Sunday evening, there were numbers about, and the tram filled quickly. A few minutes later I opened my eyes and saw a group of people at the end of the car, much excited, and one was

holding a glass of water. Evidently somebody was ill, and I was in uniform! What am I to do? I thought—if only the lights would fuse and let me slip away unseen. I rose to try and get out, but it was not to be. A voice called out, "There's a nurse! Fetch her." I can hear it now; then I knew there was nothing for it but to face the music. I mustered all my courage, hesitated a moment, and then went up as if I had walked every hospital in London.

There was a tremendous man being propped up, and someone holding water to his lips. What was the matter with him, and, oh! what was I to do? I knew enough to see that the man was unconscious and his pulse very weak. Turning to the conductor I said, "Clear the car and get me stimulants, and fetch a doctor, please." By this time the car had stopped, and several policemen and an inspector were around. I asked them to help me to lay him flat, as he was much too big a man for me to move. I got all his clothes loosened, and his collar and front off, put his head over the side of the seat, and, now for a gag, I thought. All I could think of at hand was a penknife. This I wedged in his mouth and got it propped open, put my hand in and got his tongue out. I could see nothing wrong there. A voice yelled out, "Give him brandy. Why don't you give him brandy?" I would not without a doctor's consent, as I was afraid he had internal bleeding, as his lips, gums, tongue, and membrane of the eyes were quite white. No doctor came—what was I to do? His pulse was only a flicker now, and his breathing had stopped. The police helped me to perform artificial respiration, but one of the man's arms was more than I could lift, and I split my new dress trying to move him. After hours, it seemed to me—but it could only have been a few minutes—the end came, his pulse stopped, his jaw dropped, and he was dead. I looked at my watch; it was only 7.15 p.m. A crowd had collected; I took off my cloak and covered the poor man up, as the onlookers were beginning to clamber up the car to see what was the matter. The police then asked what next was to be done, and I said run through to where you can put him up, that was Brixton.

I shall never, never forget it, Mr. Editor. The crowd was dreadful. They saw the stretcher waiting. I found myself standing in the road with my dress torn up the side, a large pin at the back to hold my skirt up, a ribbon hastily put twice round me in a knot at the back to act as a belt and hold things together, and my cloak, which had covered all my sins, was now disappearing into the police station. May you never feel as I did then, Mr. Editor; but of course you can't, as you are a man.

Could I have done anything more?—ought I to have given brandy before the man got so bad, I thought. These and a dozen more questions kept rushing through my head. Oh! for someone to talk to, someone whom I could ask if I had done right.

The inspector *would* have my address, try as I might not to give it. I got my cloak, and a little pie-dish that had had paper on it when I started out, which was going home to be refilled, got into the next tram that came along, and—of course, my luck—there were all the people I had turned out of the other car. They thought it kind, no doubt, to talk and say nice things to me, but it was more than I could stand, so had to ask the conductor to tell them to keep their seats, or let me get out.

Eventually I arrived home, and had to tell all the story, to account for my new uniform being in such a state. At 10 p.m. I was back in hospital, and glad to get to bed.

When I awoke next morning I might have been batting for Kent, or punting for hours, I was so stiff. The story got round to everyone in due time, and I got teased dreadfully when the paper came, on His Majesty's Service, to tell me to fail not at my peril to be at the inquest on a man unknown. The doctors we had in hospital at the time were most kind, and told me it would be all right and not to worry (by the by, they were old Guy's men). The day came, and I went. The poor wife said her husband had not been ill for five years, but always got out of breath on exertion. I then told my story, and then the doctor spoke. He said he got to the body about half an hour after death, and he could find nothing to cause it. I wished that the earth would open and swallow me out of sight. Then the good man went on to say he had since had a post-mortem and found an aneurism of the aorta, which, he explained to the jury, had broken and caused an overflow of blood to the heart; he also stated that if I had given stimulants it would have only hastened death.

I am not ashamed to tell you, Mr. Editor and readers, I offered up a little prayer of thanks when I heard this, and thought that doctor a dear man. I am not sure if I told you, this was the first death I had ever seen. The doctor shook hands with me and said, I had done all that could have been done. Since that, need I say, I have seen many crowds, but have always given them a wide berth if I happen to be in uniform. Pro.'s, do you blame me? For once it was not—

Wrong, wrong, you are always in the wrong,
Sweep, dust, and clean, then be asked where you've been,
Your a Pro., so don't you know
You're always wrong.

BY ONLY A PRO.

THE EDITOR will, at all times, be glad to consider articles or sketches, provided that they are accompanied by the writer's name and address, not necessarily for publication. Payment is a matter of arrangement, and the fees that the GAZETTE *can offer are merely nominal, but if the writer desires any remuneration that fact should be stated. Authors who desire reprints of their papers should make their own arrangements with the printers when they return their proofs.*

Sport.

Rugby Football.

GUY'S v. LONDON SCOTTISH.

After the lapse of some years this fixture was resumed on Saturday, January 29th, at Honor Oak Park. During the many years that Guy's and London Scottish used to play each other, Guy's were always the victors. It is a matter, therefore, for congratulation that Mr. Crook, last year's secretary, at length succeeded in getting the fixture on the card again, and in getting it played on the hospital ground. There were vague rumours on Friday about scratching the match, on account of the doubtful condition of the ground. Luckily these did not come true. It would have been a thousand pities to have abandoned such a fixture, unless absolutely necessary. So many disappointments have been the lot of local enthusiasts, that, if at all possible, it is much to be hoped the remaining home fixtures will be played.

Guy's had a full side out, with the exception of Jones and Crook, but yet had to admit defeat by 14 points to nil, a big score for a muddy playing pitch. The Scotch forwards were undoubtedly splendid, and their cleverness and quickness on the soft ground were the determining factors that piled up the score against the hospital. To be frank, the hospital pack were very slow in comparison, and their dribbling lacked the finish and completeness of the Scotchmen, also the tackling of the forwards was much too high. There was, however, one particular exception to this, and due praise should be given him for it. Hind's tackling was as certain as it was severe; the man that Hind tackled did not go on with the ball; he had to stop and shake the mud off. All the backs defended in good style; naturally their opportunities of attack were extremely few. After about fifteen minutes' play Lacey did not quite succeed in clearing before the visiting pack were on him, with the result that Lely picked up and scored an unconverted try. The same perpetual forward play resulted in another try before half-time, Monro being the scorer and Campbell converting.

Guy's had not been very dangerous hitherto, but after change of ends, a little luck and Stringer would have been in. Hind and Archer were also very nearly scorers. Then came another Scotch rush, three parts the length of the field. Hoby drove them back, but touch near the Guy's twenty-five was soon found, and from here the Scotchmen rushed away and over the line again. Kinross was the try-getter. The same forward scored a fourth and last try soon after. Neither try was converted. Guy's finished very well, but they never seemed likely to reduce the lead to any extent. The ground was very heavy, and to these conditions the home pack never became accustomed. The backs took any opportunities that came along, but they were very few and far between. Guy's had, therefore, to admit defeat by 1 goal and 3 tries to nil. Team:—

GUY'S.—G. E. W. Lacey (back); L. B. Stringer, H. Lee, J. P. Jones, A. L. Stokes (three-quarters); J. G. Saner, C. H. Medlock (halves); H. R. Mullins, H. Archer, W. E. Williams, G. R. Hind, H. Hoby, C. S. L. Roberts, W. S. Stranack, R. S. Kennedy (forwards).

REMARKS.—"It was the mud that did it." At least, so the writer was told by an old player on leaving the field, and this about sums up the reason of defeat. The heavy pack could not stand on the slippery ground, and on such days the lighter pack is bound to be the more dangerous. No further criticism seems necessary. One could not expect the backs to do any concerted attacking; so here again criticism is disarmed.

UNITED HOSPITALS v. ARMY.

This match was played at Richmond on Wednesday, February 2nd, and resulted in a win for the Hospitals by 12 points to 3, so that they can now claim the honour of defeating both Services. The game did not compare favourably with the one against the Navy a fortnight ago. There was not the same "go" about the play, neither was the passing and running in the same category as that of the Naval match. A great deal of this is accounted for by the state of the ground, and the wretched rain which drove along the ground for the greater portion of the afternoon.

From the side originally picked for the Hospitals, Lee, Crook, Morton, and Stringer stood down, letting in Lacey at full-back, Stranack and Hoby forward, and Batchelor on the wing.

Soon after the commencement the Hospitals had a bout of handling, Wilson eventually tackling Palmer very near the line. Then the Army forwards, who for a great part of the game played very strenuously, rushed the ball to the opposite end, the attack ending in Grischoth dropping for goal, and resulting in a touch down. From the "drop-out" play settled about half-way, and from here Lindsay got right away, beating Wilson by pretending to pass, and scoring in a good position. The place was taken by Adams, too close in, and was charged down. Before half-time Thomson intercepted a pass, and got through himself for a try, which equalised, as Partridge missed the goal.

The second half was spent in rushes by the forwards of both sides, interspersed by attempts at passing by the Hospitals, but the ball was very slippery, and a "knock-on" or "dropped pass" was difficult to avoid. The second half was played through all but ten minutes with the points still level. This last ten minutes was, however, just too long for some of the Army team. They showed signs of tiring. Of this their opponents took full advantage, and in quick succession added three more tries, Whyte, Heale, and Harrison being the scorers. None of these was converted, the final score reading: United Hospitals, 4 tries (12 points); Army, 1 try (3 points). Team:—

UNITED HOSPITALS.—G. E. W. Lacey, Guy's (back); A. C. Palmer, T. P. Lloyd, A. A. Adams, T. B. Batchelor,

London (three-quarters); A. S. Heale, A. B. Lindsay, London (halves); H. Archer, Guy's, A. E. Evans, Bart.'s, C. S. L. Roberts, W. S. Stranack, H. Hoby, G. R. Hind, Guy's, H. Whyte, London, T. Harrison, Middlesex (forwards).

Association Football.

GUY'S v. ROYAL COLLEGE OF SCIENCE.

2ND ROUND, UNIVERSITY OF LONDON CUP.

Result—Guy's, 1; Royal College of Science, 4.

Middlesex having scratched to Guy's in the 1st round, the Hospital entered the 2nd round of this Cup, meeting Royal College of Science at Honor Oak Park on December 15th.

This match looked like an easy win for Guy's, but disquieting news regarding the strength of our opponents made it necessary for us to put out full strength.

This was fortunate, since the Science team contained two or three amateurs who play for big professional clubs, and special mention must be made of E. G. D. Wright, outside left for Hull City. He was everything to his side, every goal originating from his centres, and this was as it should be, since nearly every pass from halves or backs, went to him.

Two of the goals seemed rather obvious off-sides, but as the referee did not interfere, there is nothing to be said. The ground was very sticky, and good football seemed out of the question.

For the first ten minutes Guy's was practically hemmed in, but at last managed to get away through the agency of Birks, only to be repelled by our opponents' backs. The game now settled down to a hard tussle, quick rushes carrying the ball from end to end.

A mistake in our defence resulted in our opponents scoring after fifteen minutes' play. This was rapidly followed by another goal. A centre from Wright, from a doubtful position, was first hooked by the centre forward out of Rook's reach.

In the second half, Guy's fairly swarmed round the R.C.S. goal, but shot after shot was saved, or went harmlessly by. Berg kicked over from a few yards out, and Bastard, with a long dropping shot, all but scored. With one or two breakaways, the College again scored, bringing their total up to four goals, whilst the Hospital put in one solitary goal, and that from a penalty.

REMARKS.—There is not much fault to find with the team. Berg is very good, but rather small for centre. McManus was slow, although he did good work. He does not get away down the wing fast enough. Neely was not quite so good as usual; this, however, was probably due to a damaged foot. Pedrick at half, and Bastard at back on the right, had most of the work to do all through the game, and they did it well, despite the goals all coming from that side. We were beaten by a better team on the day's play. Team :—

GUY'S.—H. C. Rook (goal); H. R. Bastard, H. B. Neely (backs); P. V. Pedrick, A. H. Crook, P. S. Humm (half-backs); R. M. King, S. Bevis, V. Berg, A. H. Birks, D. McManus (forwards).

GUY'S v. OLD CITIZENS.

INTERNATIONAL TROPHY DU NORD.—2ND ROUND.

This match, played at Ewell, on January 15th, resulted in a win for the hospital by 3 goals to 2. The weather was bad, rain falling all through the game; but despite this drawback the game was very fast.

The hospital kicked off uphill, and immediately pressed hard, causing the goalkeeper to save a good shot from Berg. Our opponents then broke away and set up a vigorous assault on the hospital goal. Nothing resulted, however, and from a fine individual effort Berg opened the scoring for us, the opposing goalkeeper just failing to hold the greasy ball. Shortly after this our opponents all but scored through a similar fault in our goalkeeper; this, however, was cleared, only to be returned, and from a resultant corner kick a scrambling goal was scored against us. A little before half-time Berg again scored, and the hospital crossed over, leading 2—1.

On resuming, the Citizens made every effort to level up the scores. The continuous rain had by this time made the ground so treacherous that anything like scientific play was almost impossible, but the game did not suffer from lack of pace. Berg again scored, completing his hat trick, and ten minutes from time our opponents scored. Nothing further transpired, and when the whistle blew for time the hospital left the field good winners by 3—2. Team :—

GUY'S.—H. C. Rook (goal); H. R. Bastard, J. T. Keer (backs); J. Kyle, A. H. Crook, V. Golledge (halves); R. M. King, S. Bevis, V. Berg, W. Matthews (forwards).

REMARKS.—Although the team was weak on paper, every man played up well, and the win was thoroughly deserved. Rook dealt with his shots well, except perhaps for just a little over-confidence. This is, at present, rather more a fault than a virtue, but doubtless he will realize that too much confidence is sometimes disastrous, and by toning it down somewhat convert it into a virtue. It is certain that no safer goalkeeper has been seen up at the hospital for some time. Bastard and Keer were in fine form at back, and no fault could be found with the halves. Kyle has improved considerably; Crook was even more bustling and effective than usual. Golledge will stand a chance for a place in the Cup team if he always plays as well as he did in this match. In regard to the forwards, they, as a whole, played well, King, Bevis, and Berg being especially prominent. Bevis must bustle rather more when accepting or intercepting a pass. Berg, although slightly selfish, was individually perfect. All his goals were good, and hardly won, and he shows a natural aptitude for being in the right place when the ball comes out of a scrum near goal.

Death.

HANCOCK.—On January 26th, William Ilbert Hancock, F.R.C.S., in his 37th year.

ED.—A. N. C.

GUY'S HOSPITAL GAZETTE.

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Calendar of Coming Events and Ensuing Take-in Weeks.

February.

Sat. 19. 1st XV. v. Old Leysians (Home).
2nd XV. v. Harrow (Away).
2nd XI. v. Lee Reserves (Home).

Mon. 21. Clinical Lecture by Mr. Turner (Otology), 1.15 p.m.
Physiological Society's meeting, 4 p.m.

Wed. 23. Physical Society's Meeting, Paper by Mr. Marshall, 8 p.m.

Thur. 24. Messrs. Symonds and Steward's Take-in (Messrs. Crook and Mills).

Sat. 26. 1st XV. v. Old Alleynians (Home).
2nd XV. v. U.C.S. Old Boys "A" (Away).
1st XI. v. Old Tollingtonians (Home).

Mon. 28. Clinical Lecture by Mr. Bellingham Smith (Gynæcology), 1.15 p.m.
Physiological Society's Meeting, 4 p.m.

March.

Wed. 2. Physical Society: Pathological Meeting, 8 p.m.

Thur. 3. Messrs. Lane and Fagge's Take-in (Messrs. Mullins and Fitzmaurice).

Passim.

AT the recent Quarterly Comitia of the Royal College of Physicians, Dr. Newton Pitt was elected the Bradshaw lecturer for the present year, and Dr. A. E. Boycott the Milroy lecturer for the year 1911.

THE first round of the Inter-Hospital Rugby Cup Tie was concluded on Thursday last by our match against Charing Cross, which is reported elsewhere in this issue. We won by the not very substantial score of a goal and a try to nil. The results at the other hospitals were more or less as expected: London beat King's, Bart.'s beat St. Mary's, University beat Westminster, and St. Thomas's beat Middlesex. In the next round we meet University; this match will be played at Richmond during next week.

MR. MULLINS, the popular captain of our First XV., has so many friends outside as well as inside the hospital, that it is just possible some of them have not yet heard of the unfortunate stroke of ill-luck which has befallen him just as the climax of the football season is approaching. Mr. Mullins was take-in H.-S., and on the last day of the week he had the unenviable privilege of taking himself in for an attack of appendicitis. Mr. Lane operated the same evening, and we are happy to say that the patient is now making good progress towards recovery. But it is indeed hard lines, after years of steady and unselfish work in the service of the hospital team as secretary and player, years during which he has seen, and to a large extent made, the Guy's forward line become one of the finest in the country, that he should now, in the year of his captaincy, be debarred from taking part in the Cup-ties, and from leading his team once more to victory. We join with all his friends, inside and outside the hospital, in expressing our sorrow for his ill-luck and our hope that he may have a quick and uninterrupted recovery. It is scarcely necessary to say that the rest of the team will do their utmost to retain the Cup, and so do their captain credit.

THE secretary of the Physical Society asks us to remind our readers that essays on "The Etiology and Pathology of Pigmentation in Constitutional Disease," for the Treasurer's

Prize, should be sent to him on or before Monday, March 7th. The paper chosen for the prize will be read at the meeting held on March 16th, when Dr. Hale White will take the chair.

A CORRESPONDENT has kindly sent us a selection of leaflets issued by the Navy League, with the request that they should be distributed to those who have never heard of the League and its work, and he asks us once more to refute the idea, still not exploded in some quarters, that the League is a party organisation or exists for purposes of party politics. He thinks that Guy's men should take a part in such a movement, and in this connection it is interesting to note that several prominent members of our staff were among the signatories to a letter which recently appeared in the *British Medical Journal* containing a proposal to form a medical branch of the Navy League. We believe that a number of present Guy's men already belong to an organisation called "The Islanders," which has somewhat similar aims, but no doubt there are many others who would like to take a share in the work of the older society—the Navy League.

ON Wednesday and Friday next week, at five o'clock each day, Mr. W. Sampson Handley (Hunterian Professor) is giving two lectures on a subject which he has made especially his own—"The Surgery of the Lymphatic System." The lectures will be delivered in the theatre of the Royal College of Surgeons.

LAST week-end a four nights' performance was given in Chelsea of "The Illustrious Stranger," a comic opera founded upon an old play of the same name, words and music written by Dr. Gardner, an old Guy's man. The music was scored by A. L. Gardner, and many of the parts were played by Guy's men. As the handsome and *débonnaire* Prince Azan, O. Parry Jones made a successful début, his two duets with the Princess Lakmah (Miss Pullein Thompson) being exceedingly good. The part was originally written for a tenor voice, but the transposition did not affect the music much, and the higher parts suited Parry Jones' voice excellently. E. Billing was good as the cadaverous Mummy-maker general. His long solo on a monotone showed that he clearly was "cut out" for the neighbouring profession. To L. C. D. Irvine was given the part of the rich and pompous court physician. He certainly seemed thoroughly to enjoy a clever "patter song" in it, and seemed quite at home in the love-making scene. He was, unfortunately, unable to play on the last two nights, but his part was very well given by D. A. Mitchell, to whom great credit is due for having got up a long part in a very short space of time. In his own part as Sing-Hi, the Court Policeman, Mitchell was monumentally impassive. The other parts, played by men outside the Hospital, were exceedingly good, but the whole play would have been a failure without Dr. Gardner himself, as Benjamin Bowbell, the Illustrious Stranger. Dr. Gardner was in turns humorous, stately, and pathetic, and the fact that the second act was immensely better than the first was due entirely to the absence of Benjamin in the first. The music was good, and special mention must be made of a song, "Naughty Little Cupid," most excellently sung by Miss Dignan, as Zeta, the Princess' attendant.

A SHORT time ago, before the flood, an anonymous correspondent in Paris sent us the following extract from the advertising columns of a French paper:—

> WANTED an instructor or instructress capable of teaching the English language without impoverishing it with the usual solecisms and unintelligible jumble of French words. No English need apply, Germans preferred.

Our correspondent comments on this as follows:—"The result of a *bad* education, and the snobbish and *unpatriotic* use of foreign words." The language of physical signs must give our correspondent much sorrow, for we have borrowed it practically all from the French, and in the case of the word *bruit*, we quite agree that the English equivalent should be used instead, but it is surely going too far to dub the use of foreign words "unpatriotic." However insular we may be geographically, we cannot claim to be insular in language. It was, no doubt, a highly patriotic movement to substitute "napkin" for "serviette," but there are some words such as "éclat," "savoir-faire," "gaucherie," "chauffeur," "ménage," and above all the invaluable "fiancé," which we cannot easily do without and for our part we cannot see why we should attempt to do without them. This is a matter of mutual exchange; we have given to the French the language of football and horse-racing, for instance; and we need not be shy of borrowing from them the language of motoring, of fencing, of dramatic criticism, even of auscultation.

Nursing News.

Matron's Office.

Miss Ethel Clifford, who has been Sister of the Electrical and Light Department since April, 1908, left the Hospital on December 15th last. Miss Alice Hart, who has been acting as Medical Night Sister since September, was transferred to the Light Department, and Miss M. Hancock, who completed her three years' training in August, 1909, was appointed Probationary Medical Night Sister.

Nurse Hilliard left the Hospital on November 25th, 1909, on completion of her three years' training, and Probationer Lowe was appointed to succeed her as Head Nurse in Stephen Ward.

Nurse Ekins, Head Nurse in Patience Ward, left the Hospital on November 27th, 1909, on completion of her three years' training, and Probationer Nixon was appointed to succeed her as Head Nurse.

Nurse Corbishley, Head Nurse in the Surgery, left the Hospital on November 30th, 1909, on the completion of her three years' training, and Nurse Clifford was appointed to succeed her as Head Nurse.

Nurse Jarvis left the Hospital on December 1st, 1909, on completion of her three years' training, and Probationer Mawson was appointed to succeed her as Head Nurse in Dorcas Ward.

On December 1st, Probationer Prescott was appointed to succeed Nurse McMorland as Head Nurse in Bright Ward.

On December 7th, Nurse Bodenham was transferred to Stephen Ward, and Probationer E. Smith was appointed to succeed her as Head Nurse in the Out-Patient Department.

Nurse Bottomley left the Hospital on December 11th, 1909, on completion of her three years' training, and has since been appointed District Nurse at Blandford. Probationer A. Browne has been appointed to succeed her as Head Nurse in Cornelius Ward.

Nurse Irvine, Head Nurse in John Ward, left the Hospital on completion of her three years' training on December 31st, to take up District work in Ireland. Probationer Cruickshanks has been appointed to succeed her as Head Nurse in John.

On December 16th, Nurse Marsh was transferred to Addison Ward, and Nurse Ballance was appointed to succeed her as Head Nurse in the Massage Department.

Probationer E. Blenkarn was appointed Head Nurse in Stephen Ward on December 18th, 1909.

Nurse Gardner left the Hospital on December 31st, 1909, on completion of her three years' training, and Probationer Salmon was appointed to succeed her as Head Nurse in Esther Ward.

Nurse Venning left the Hospital on January 1st on completion of her three years' training, and Probationer Hunt was appointed to succeed her as Head Nurse in Lydia Ward.

Nurse Krauth left the Hospital on completion of her three years' training on January 1st, and Probationer Aston was appointed to succeed her as Head Nurse in Lydia Ward.

Nurse Tyers left the Hospital on January 4th on completion of her three years' training, and Probationer Sutton was appointed to succeed her as Head Nurse in Martha Ward.

Nurse Jefferson, Head Nurse in Stephen Ward, left the Hospital on completion of her three years' training on January 6th.

Nurse M. Carey left the Hospital on completion of her three years' training, and Probationer Howe was appointed to succeed her as Head Nurse in Dorcas Ward.

Nurse Collingwood left the Hospital on January 11th on completion of her three years' training, and Probationer S, Lewis was appointed to succeed her as Head Nurse in Addison Ward.

Nurse Moss left the Hospital on completion of her three years' training, and Probationer Myers was appointed to succeed her as Head Nurse in the Eye Wards.

Nurse McKitrick left the Hospital on January 26th on completion of her three years' training, and Probationer May was appointed to succeed her as Head Nurse in Bright Ward.

Nurse K. Stewart left the Hospital on February 3rd on completion of her three years' training, and Probationer Rees was appointed to succeed her as Head Nurse in Queen Ward.

Nurse Kerr left the hospital, on completion of her three years' training, on February 13th, and Probationer Sladen was appointed to succeed her as Head Nurse in Naaman Ward.

Nurse Bishop left the hospital on February 17th, on completion of her three years' training. Nurse L. Turner was appointed to succeed her as Head Nurse in Miriam Ward, and Probationer Lustic was appointed Head Nurse in the Theatres.

The Prize List for highest number of marks gained in the Nurses' Examinations for 1909, is as follows:—

Medical Examination: Probationer Todd. Surgical Examination (Keogh Prize): Probationer Hinds and Probationer Yates, equal marks. Nursing Examination: Probationer Giles.

The Cazenove Medals awarded to the Nurses gaining the highest number of marks in the three examinations, have been gained by: 1st, Probationer Hinds; 2nd, Probationer Yates; 3rd, Probationer Todd.

The following Probationers have been successful in passing the Medical Examination: Probationers Achurch, Balkwill, Baker, Beirne, Bigg, C. Blenkarn, Boniface, Bordillon, Brereton, Calvert, Clarke, Collett, Colston, Cox, Cronin, Daly, Eaton, Edwards, N. Foster, Goddard, Grant, Greaves, Hodgkinson, Hutton, Iles, Kirby, Kirkham, Knight, Lane, Lay, F. Lear, Mannell, Matthews, McLaren, Middleton, Millar, N. Moore, Mutford, Naylor, Noble, Oldershaw, Orchard, Owen, Phillips, A. Prince, Quin, Rudd, Salter, Schlagentweit, Shann, Sime, Strange, Stevens, Teague, Templeman, Thomas, Thomson, Tilleard, Todd, Tyson, C. A. Ward, Waters, Waterman, Windley, Windemer, Yeoman.

The Functional Examination of the Auditory and Vestibular Apparatus.

By W. M. Mollison, M.A., M.C.
(Arthur Durham Travelling Student.)

Part I.

The auditory apparatus consists essentially of two parts—the one part serves to conduct the sounds, and may be called the conducting portion; the other serves to receive and appreciate the sounds, and may be called the *receptive apparatus*.

The *conducting apparatus* consists of the external ear, the external auditory meatus, the tympanic membrane and the ossicles (lying in the tympanum). This comparatively complicated mechanism serves to bring the sound waves to the foot of the stapes fitting into the oval window, the entrance to the inner ear.

The *receptive apparatus* consists of the cochlea with its endolymph and complicated organ of Corti with nerve fibres leading therefrom. This organ of Corti may, from the point of view of its function, be considered to consist of a series of minute fibres which are stretched like fine wires capable of vibration. These wires vary in length, the shortest responding to high tones and the longest to low tones, with a complete series between. The highest and lowest tones capable of being appreciated by the human ear vary, but roughly the lowest is a sound consisting of thirty vibrations per second, and may be exemplified by the low pedal notes of an organ, while the highest is a sound represented by four thousand vibrations per second, and is comparable to the squeak of a bat. It is obvious that these wires can be set in motion, not only through the medium of the foot plate of the stapes, that is, the conducting apparatus, but also by vibrations received direct through the bone.

In close connection with the receptive auditory organ there is the *vestibular apparatus*. This apparatus, though forming part of the so-called inner ear, has a different function from the cochlea; it consists of a small space—the vestibule—with certain highly specialised perceptive cells therein, and the three semicircular canals arranged in the three planes of space opening into it; the whole being connected with the vestibular portion of the auditory nerve; the canals containing endolymph. This vestibular apparatus is essential to co-ordination; through it, position of the limbs is appreciated, and the normal position of the body maintained in rest and motion; in this function it is assisted by various senses, namely, sight, touch and muscle sense.

Considering the examination of the auditory apparatus proper, it is obvious that the results of examination of the function of each part depend to a great extent on the condition of the other; thus, though each part can to a certain extent be examined alone, it is difficult to exclude examination of the other.

The examination of the function of the vestibular apparatus, on the other hand, is not interfered with by the condition of the cochlear apparatus, though in a large percentage of cases of disturbance of the vestibular function there is also disturbance of the auditory function, or rather the vestibular disturbance is secondary to the disturbance of the auditory function brought about by an extension of an inflammatory process.

In view of these considerations, the examination of the functions of the "conducting" and "perceptive" parts of the auditory apparatus is to a large extent carried out simultaneously. The complete examination for accurate work can be prolonged more or less indefinitely, but here it is proposed to give the scheme, slightly modified, used in Professor Alexander's Klinik in Vienna, with added explanations and comments.

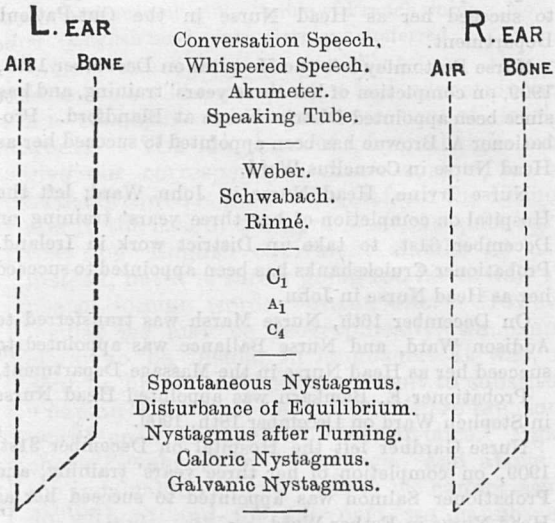

Fig. 1.—General Scheme for the Functional Examination after that used in Prof. Alexander's Klinik.

I.—The Examination of the Auditory Apparatus.

Each ear is examined separately for its perception of the voice, both the ordinary speaking

voice and the whispering voice. This method of examination is most useful, because the appreciation of the voice is the most essential function of the ear from the patient's point of view; it may be thought to be very rough and inaccurate, but if the same set of men (accustomed to the examination of the patients), or better, the same man, examine the patient, the results are sufficiently accurate to be of value. Experience has taught that whispered conversation can be heard by normal people from a distance of 15 metres (about 18 yards). Using this as a standard, and indicating the distance between the examiner and the patient in metres, will give a good idea of the degree of deafness. If greater accuracy is required an "Akumeter" may be used; this is an instrument so constructed that a small piece of metal falls a definite height on to another piece of metal, thereby always making the same amount of noise. This is an interesting method of examination as it forms a universal standard for comparing exactly the hearing power of patients; on the other hand, it is not very practical, because of the special kind of noise produced by the instrument.

There is yet one important method of examination for the voice; some patients are so deaf in one ear that the voice must be considerably raised to make them hear at all, and in such cases it is extremely difficult to exclude the other ear even though it is kept tightly closed. To overcome this difficulty, a long rubber tube with an earpiece, which the patient applies to his ear at one end, and a mouthpiece into which the examiners speak at the other, is used. It has been found that with such a tube the slightest whisper can be heard by the patient if he has any hearing left, but if the hearing is nil, then the words spoken are not heard at all.

II.—Examination of the Bone Conduction.

For this three tests are made:—

a. Weber's test.—This consists in placing the stem of a tuning fork (one having a note in the middle of the scale is generally used) on the skull in the middle line, and noting on which side the sound is appreciated by the patient.

In normal persons the sound cannot be localised to one side more than the other, but in patients with any obstruction to the conducting apparatus the sound is appreciated on the affected side. Thus, wax in the right ear would cause the fork to be heard on the right more than the left so long as the left ear were normal. This test, therefore, is very useful to decide on which side the conducting apparatus is defective so long as the perceptive apparatus is sound. Naturally if the perceptive apparatus is also affected, then the test fails to give results of any worth. This test also must always be judged with care, and not be relied on implicitly, because in many apparently perfectly normal persons the sound is referred to one or the other side, and in many cases of known defect in the conducting apparatus, it is referred to the sound side, in exact contradiction to the expected result.

b. Schwabach's test.—This is performed very much as is Weber's, but here the condition of the bone conductor is estimated by comparing it with that of a normal person (the examiner). The time during which the fork is heard when held on the skull regardless as to whether it is heard in one or the other ear.

In carrying out this test several factors must be taken into consideration: the thickness of the soft parts over the bone, irregularities in the bone, and effect of age on the skull (conduction by the bone is always worse in older than in younger people, so that in a man of fifty some shortening of the time during which the fork was heard would have no great significance). Bearing these factors in mind, and allowing for them, Schwabach's test gives an idea of the irritability of the perceptive apparatus apart from the conducting apparatus. Nevertheless, by itself it is not of great practical value, and the next test can largely take its place.

c. Rinné's test.—This test is applied to either ear in turn. If the tuning-fork is placed alternately in front of the ear and on the mastoid process, it will be found that it ceases to be appreciated when on the mastoid sooner than when in front of the ear; that is to say, "air" conduction is better than bone conduction—this is the normal reaction, the "positive Rinné." When the opposite condition obtains and the fork is heard longer on the bone than in front of the ear, the condition is abnormal, and a "negative Rinné" is present. If air conduction and bone conduction be represented by two vertical lines, then the normal relation will be represented by drawing the air line a little longer than the bone line; this is shown on the scheme affixed, and it is seen that the line joining the extremities of the two lines slopes from the "bone" line down to the "air" line. In the case where Rinné is negative, the slope of the line will be in the opposite direction.

What is the value of this test? The mere relation of "air" to "bone" conduction does not give much information about the function of the ear, because both "air" and "bone" conduction may be very much shortened and yet the relation be normal.

But if at the same time the actual duration of the bone conduction compared to a normal person is noted, also the duration of the air conduction, the test becomes much more important, and gives definite information about the function of the auditory apparatus.

The above-mentioned graphic representation is very useful, and gives a simple means of stating the condition found.

The three examples (Fig. 2) will be, perhaps,

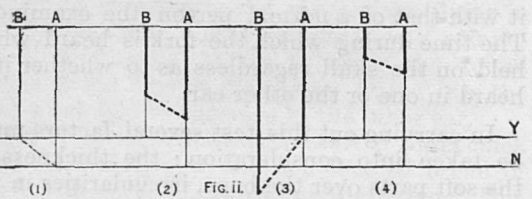

FIG. 2.

useful to explain the application of this representation.

The letters B and A represent bone and air conduction respectively, and X Y the distance to which the "B" line reaches, and M N that to which the "A" line reaches.

1 is the normal condition, A a little longer than B.

2 is the condition where both A and B are shortened, the relation remaining as before.

3. The condition where the bone conduction is lengthened while the air conduction is shortened, and the relation of the two is just opposite to the normal. This is the relation most often found in chronic otitis media.

4. Represents greatly shortened B and A lines, while the relation remains as in the normal case.

It is quite clear, therefore, from this that the mere fact of a "positive Rinné" alone can be quite misleading and not give any true indication of the state of the auditory function.

III.—EXAMINATION BY TUNING-FORKS.

As has been said, the cochlea consists of a series of strings arranged to perceive tones of very various wave lengths, and those fibres to perceive high tones are in the base of the cochlea. This base or first turn of the cochlea gives rise to a projection on the inner wall of the tympanum, and is called the promontory. This part of the cochlea, therefore, is the first part that is apt to be affected by inflammatory processes originating in the middle ear.

The examination of the function of the auditory apparatus (the cochlea and its nerve endings) is carried out by means of tuning-forks. Theoretically, for the complete and exact examination of the cochlea an enormous number of forks would be required in order to set in vibration the individual fibres, from the longest to the shortest. In practice this number is limited to thirty, roughly; and this complete series is only used in cases of special interest. By testing the patient's perception with this series of forks the whole cochlea is tested, and localised defects in it can be discovered. That this complete testing is needed is explained by citing classes of cases; the first is that of *luetic deafness*, where the loss of hearing is found often to be confined to the middle tones, both the low and high being still well heard; and the second is that of *congenital deafness*, where the cochlea may be quite irregularly affected, only a small part of the whole scale being appreciated at all, and the position of this functionating part can be of considerable importance in the education of the child.

That such an elaborate method of examination is quite unnecessary in the vast majority of cases is obvious, and in consequence a much simpler is used, which is at the same time reliable. It is customary to use three different tuning forks: one with a low tone, one with a very high tone, and one in between, having a tone in the middle of the scale; this last is also used to make all the previously mentioned tests. Those forks actually used in the Alexandra Klinik are the so-called—

C_1, having 64 vibrations a second.
A_1, having 435 vibrations a second.
c_4, having 2048 vibrations a second.

With these three forks all cases can be quickly and efficiently tested, and should a case be thought to require more exact testing, the large series of forks is resorted to.

It is interesting to give examples of the results obtained by these tuning-forks.

It will be found that in a very large percentage of cases of deafness examined by the low fork (C_1), perception is diminished; this does not by any means indicate that the apex of the cochlea is affected; the cause is to seek in the conducting apparatus, low tones being easily obstructed by defects in the conducting apparatus; thus retraction of the membrane tympani, thickening of the membrane, a chronic catarrh, fixation of the ossicles, will all cause

diminution in the perception of the low tones. It is thus seen that loss of perception of C_1 is often an indication of middle ear disease, and not of beginning primary nerve deafness.

The middle fork (A_1) has already been used in the Rinné test where the relation between bone and air conduction is estimated. Now the middle fork is used to compare the air conduction with the normal (the examiner) and thus to give Rinné's test more meaning (q.v.). At the same time, the fact that A_1 is not well heard may indicate loss of function in the middle region of the cochlea. The test with the high fork (C_4) is, perhaps, the most important, because it is very little influenced by the condition of the conducting apparatus, its vibrations passing through to the cochlea (on account of the very short wave-length of this high tone).

If now it is found that the perception of C_4 is diminished, it means that the fibres at the base of the cochlea are affected, and therefore indicates a nerve-deafness. This nerve-deafness may arise from a primary affection of the perceptive apparatus, or it may be of an inflammatory or degenerative nature secondary to middle-ear inflammation which has spread through the foot of the stapes. Whichever is the cause the fact is of great importance in prognosis. Particularly is this so in those cases of chronic otitis media, for if before operation the perception of high tones is found diminished, then the prognosis for hearing after radical operation is poor; but if the perception is good, then the prognosis is better; in the first case the inflammatory process has spread to the inner ear, and in the latter it has not, or, if it has, not to such an extent as to involve the cochlea function.

This completes the functional examination of the auditory apparatus: if the various tests are passed in review it will be seen that no one test is of essential value alone, but must be always combined with others, and no definite opinion can be expressed unless all these tests are considered and estimated at their proper value.

Appointments.

Naval and Military.

Staff-Surgeon G. E. Duncan, R.N., has been appointed to the *Sentinel*.

J. R. Palmer, L.D.S., and H. Gordon Spain, L.D.S., have been appointed Dental Surgeons to the *Ganges II.*, Harwich, and the Royal Marine Hospital, Deal, respectively.

Captain H. W. P. Barrow, R.A.M.C., is promoted to be Major.

Correspondence.

To the Editor of Guy's Hospital Gazette.

Constipation.

Dear Sir,—In the Gazette of January 8th appears an interesting and instructive clinical lecture by Dr. Hale White on Constipation. This subject appeals in an especial manner to us general practitioners, as there is perhaps no minor trouble for which we are so often consulted, and of which we see so much, as constipation.

Will you allow me to add a few remarks on this subject to what Dr. Hale White has said?

First, as to the state of the teeth. May it not be that, equally in young children, in adults and in old people, the primary cause of constipation is often to be found in the mouth? The presence of carious teeth, and the absence so often of any efficient molars, so prevents mastication that the food is necessarily swallowed *en bloc*. At any rate, I often have noticed that patients with a good set of teeth do not suffer from constipation so much as those with deficient powers of mastication.

The neglect to attend to the call of nature *there and then* is, I believe, a fertile cause of the trouble. If the call, when it comes, is not attended to at the time, a second opportunity may never occur spontaneously.

There is one drug not mentioned by Dr. Hale White which I have used in my practice for years, and find invaluable. I refer to the drug which passes under many trade names, and which I first heard of under the crack-jaw name of Dihydroxythalophenophone. The form I use is made by Warwick Bros., and is put up in so-called Pulvellæ—really a gelatin-coated capsule. There are two strengths, containing 2 grs. and 3½ grs. respectively. These, I find, act surely and painlessly, and, so far, I have never been able to trace any after-constipation due to their use, nor does the patient require to have the dose increased, as in so many other aperients.

Another useful article not mentioned by Dr. Hale White is the glycerine suppository. These also I use largely, and those made by Parke, Davis & Co. I find the best. They are firmer and easier of insertion than those of other makers, and being in the form of a torpedo, thickest in the middle, are quickly inserted and easily retained. I carry a bottle of them in my midwifery bag, and in lying-in cases insert them instead of using a soap-and-water injection. They are more cleanly, sure in action in most cases, and cause no fuss. I also carry a bottle with me in my bag on my daily rounds, and often find them of service.

Finally, as to exercise. In the April number of the *Royal Magazine* for 1905 there was pictured and described a series of exercises, which could be done in about two minutes, and which, if faithfully carried out daily before breakfast, will be found of immense benefit,

not only in keeping the system generally in good muscular tone, but also in preventing constipation.

I can vouch for this by my own experience and by the experience of patients to whom I have taught these exercises. An illustrated chart to hang up in the bath or bedroom, showing the various movements, can be bought for the sum of ninepence from Messrs. Pearson & Co., of Henrietta Street, W.C., the proprietors of the *Royal Magazine*.

The effect of these exercises, which are very simple and require no apparatus, is not only to increase the muscular tone of the body generally, but, I believe, also has a direct result in forcing the food through the intestine, probably also increasing peristaltic action. I should like other medical men to try them, and then give you their experience. I would advise the exercises to be repeated right and left, with the mouth tightly closed, from two to six times on rising in the morning. They are gentle exercises and could safely be carried out, I imagine, by people of all ages.—I am, etc.,

T. REUELL ATKINSON.

Chadwell Health.

The late Mr. W. I. Hancock.

DEAR SIR,—The following abstract from a letter written to me by Dr. Wilson Tyson, of Lowestoft, will, I am sure, commend itself to many of your readers:—"I was awfully sorry to hear about poor Bertie Hancock. It does seem cruelly bad luck. I should very much like to see some sort of memorial to keep green the memory of one of the best all-round sportsmen that Guy's has ever known. Probably a good many of the men would subscribe towards a fund, and a really good portrait, to be hung either in the smoking-room or in the pavilion at Honor Oak Park, would be nice. I shall be very pleased to contribute if any such scheme is carried out, and if you think fit, perhaps you will ventilate the subject." Dr. J. Fawcett, Mr. F. J. Steward, and Mr. F. D. S. Jackson have consented to join Dr. Tyson and myself in forming a committee to carry out the above project, towards which I shall be glad to receive any subscriptions not exceeding 10s. in amount.—I am, yours very truly,

C. H. FAGGE.

3, Devonshire Place, W.

16th February, 1910.

Change of Address.

M. E. Ball, M.B., B.S. Lond., L.R.C.P., M.R.C.S., from Guy's Hospital, to Holmside, Emsworth, Hants.

Richard J. Bentley, M.B., B.S. Lond., L.R.C.P., M.R.C.S., from Crayke, Frome Park Road, Stroud, to Northend, Ashford, Kent.

T. N. Wood, L.R.C.P. Lond., M.R.C.S. Eng., from the Queen's Hospital for Children, Hackney Road, E., to the Victoria Hospital, Burnley, Lancashire.

(The Editor will be very glad to receive a postcard with notes of any change of address.)

Notice.

University of London: Officers Training Corps.—Medical Unit.

NOTICE OF LECTURES.

Lt.-Colonel H. E. R. James, F.R.C.S., will give the following lectures on the subjects for Certificate "B," at Guy's Hospital, on Thursdays, at 5.15 p.m., February 24th and March 3rd, 10th, and 17th:—

The subjects of the lectures will be:—

1st. "Organization of the Army and its Government." "The Organization of the Army Medical Service and its Duties."

2nd. "Organization of the Army Medical Service for War." "Medical Field Units."

3rd. "Ambulance Material, Hospital Trains, Hospital Ships."

4th. "Care of Troops in Barracks, Camp, and on the Line of March."

Lt.-Colonel C. H. Melville, R.A.M.C., Professor of Hygiene at the R.A.M. College, will give the following lectures on Tuesdays, at 5.30 p.m., at the Royal Army Medical College, Millbank:—

February 15th, on "Water and its Purification."

March 1st, on "Sanitation of Camps."

March 15th, on "Hygiene of the March."

EXAMINATION FOR CERTIFICATE "A"

The following Cadets qualified in the examination for Certificate "A," held in November, 1909:—

MEDICAL UNIT—B SECTION.

No.	Name.	No.	Name.
3061.	Allen, T. S.	3100.	Mitchener, P. H.
3062.	Annesley, F. D.	3102.	Moore, J. Y.
3063.	Banbury, R. A.	3108.	Perceval, J. L.
3066.	Campion, R. B.	3110.	Potter, A. F.
3071.	Corbett, W. V.	3113.	Robinson, W.
3072.	Cowtan, F. C.	3114.	Rook, H. C.
3079.	Foley, W. B.	3115.	Saunders, E. G.
3083.	Gatley, C. A. R.	3118.	Sherris, C.
3085.	Godding, F. C.	3119.	Smith, A. J. E.
3086.	Godding, H. C.	3126.	Warner, H. P.
3087.	Hancock, A. C.	3127.	Webb, W. L.
3098.	Messenger, H. L.	3088.	Harrison, S. S. B.
		3117.	Shearwood, A. L.

Extract from the Orders for the Week ending Saturday, February 19th.

A. G. EGERTON,
Captain and Adjutant.

University of London O.T.C.

Papers by Guy's Men.

W. Hale White, M.D. Lond., F.R.C.P. Lond. A Clinical Lecture on a Case of Subphrenic Abscess.—*The Clinical Journal*, 9th February, 1910.

Purpura.

ABSTRACT OF A CLINICAL LECTURE BY Dr. HALE WHITE.

Gentlemen,—A woman, aged 36 years, came into Miriam ward on November 25th suffering from purpura, with bleeding from the nose. She had purpuric spots on the breasts, back, and thighs; many of these, she told us, appeared about a month previously, and afterwards became better, but did not entirely disappear. Four days before admission more spots appeared, and she had attacks of vomiting. On the next day she was again sick, bled from the nose, and had shivering fits. On admission she was obviously ill, had persistent and slow hæmorrhages from the nose, and was shaking as though she had a rigor all the time. The pulse was good, but rapid. The temperature was a little raised. There were several signs of recent and old hæmorrhage under the skin, some being in the cellular tissue around the left eye, but apparently she had not bled very much, for she was not blanched. The bowels were regular, there was no trace of œdema anywhere, the heart was not hypertrophied, and the arteries were not thick. The optic discs and retinæ were perfectly normal; the liver could just be felt, but there was no reason to suppose that anything was the matter with it; there was no vaginal discharge; the urine contained a trace of albumin, but it should be particularly noted that there were no casts. On looking at the mouth it was evident that there was a certain amount of pyorrhœa. All the teeth were loose, and the gums were swollen and obviously inflamed. On the evening of the day of admission the epistaxis was worse, and the shivering or twitching was more marked. The day after admission the condition was still more grave, the patient was semi-conscious, and in the afternoon it was observed that very little urine was being passed. In fact, the amount of urine passed fell to three ounces in twelve hours. At 8 p.m. she was still unconscious and had frequent convulsions, which continued throughout the night. She died early the next morning. At the *post-mortem* examination no subpleural hæmorrhages were found, there was nothing wrong with the heart, and there were no internal hæmorrhages in the brain or in any of the usual situations for them. I will not at this point say what was actually discovered, but I will refer to it later in the course of my list of the causes of purpura.

The obvious thing about the case was that the patient was covered with a number of hæmorrhages underneath the skin. What are the causes of such a condition? I have drawn up a list of the various causes of purpura, and we must go through that list systematically, and try to decide which was the cause in the case now before us. The late Sir Stephen Mackenzie published a list of two hundred cases of purpura, compiled from the case-books of the London Hospital, and as the general run of the cases at the London is not greatly different from that at Guy's, the list may serve us as a basis, but we must add some causes which do not occur in Mackenzie's list, and then we get the following table:—

LIST OF CAUSES IN 200 CASES OF PURPURA.

Rheumatism	61	Leucocythæmia	1
Doubtful rheumatic	10	Malaria	1
Bright's disease	9	Rickets	1
Heart disease	8	Whooping-cough	1
Anæmia	6	Cirrhosis of the liver	1
Scurvy	6	Hæmophilia	1
Privation	5	Varicose veins	1
Tuberculosis	4	Peripheral neuritis	1
Toxic (drugs)	3	Specific fevers	0
Septicæmia	2	Jaundice	0
Malignant endocarditis	2	Serums	0
Congenital syphilis	2	Henoch's purpura	0
Alcoholism	2	Multiple sarcomata	0
Convalescence	2	Unexplained	68
Injuries	2		
			200

Clearly the first thing we must do when a patient suffering from purpura comes before us is to ask whether he has rheumatic purpura, which accounts for 61 out of the 200 cases. People who are rheumatic—that is to say, people who have had rheumatic fever, or severe growing pains when children, or any other rheumatic manifestation—are liable to purpura to a greater extent than others. Rheumatic purpura, however, has certain characteristics which enabled us to say positively that the case in question was not of this class. Rheumatic purpura is nearly always best marked on the shins. The usual thing is for the sufferer to wake up in the night with a smarting feeling in the front of his leg, and an accompanying redness of the skin. By the morning it is better, except that there is some swelling and, perhaps, a little extravasation of blood. On the following night the symptoms present on the first night are repeated, and by the morning there is a considerable swelling. The discolouration begins as an erythema, hence the name erythema nodosum, and it goes on to the actual extravasation of blood. Rheumatic purpura is very

rarely found all over the body; it is usually confined to the limbs, and seldom appears on the trunk. And I cannot call to mind a patient with rheumatic purpura who had bleeding from the nose; one of the features of our case was the profuse epistaxis. Minute hæmorrhages may, indeed, be found under the pleura in the rare cases in which there is an opportunity to obtain a *post-mortem* in rheumatic purpura, but hæmorrhages here are common in other conditions, and for all practical diagnostic purposes the bleeding in rheumatic purpura never occurs from any internal surface, or in any internal organ. It is confined to the skin, mostly of the extremities, and generally of the lower extremities. Rheumatic purpura is very rarely seen in a person under the age of ten. Before leaving this part of the subject, I may point out to you a difficulty in nomenclature. *Peliosis rheumatica* is a term often applied to rheumatic purpura, and its misapplication has led to much trouble, because the physician Schönlein, who was the first to recognise that rheumatic patients were liable to purpura, described as peliosis rheumatica certain cases which were mostly examples of erythema papulatum, and had nothing to do with rheumatic purpura at all. There was no evidence that our patient had been subject to anything of a rheumatic nature, nor that the purpura was rheumatic.

Nine of the cases in our list were due to Bright's disease. That is of great importance. I do not know that there are many things I would sooner you remembered in medicine than that people with Bright's disease are liable to bleed from any part of their body. They may bleed into the brain; from the nose, and so have epistaxis; and those who use the ophthalmoscope know that there may be bleeding in the retina. But many students do not remember that in chronic Bright's disease bleeding may occur in any part of the body. I remember a patient, a young man of about thirty, who had a hæmatoma in his ear. He had had no blow which could cause it. We found that he had albumen and casts in the urine, and although he was apparently healthy, the hæmorrhage into the lobe of the ear directed attention to the fact that he had chronic interstitial nephritis. It is now recognised that it is not uncommon in chronic nephritis for hæmorrhages to be found in the mucous membrane of the intestine or the stomach, and it is suggested that some of the ulceration in the intestinal tract met with in chronic nephritis is really due to these hæmorrhages. A patient has hæmaturia, and if we do not recognise that the sufferer from chronic granular nephritis may bleed from the urinary tract we may fail to properly interpret the hæmaturia, Hæmoptysis may be due to chronic nephritis, and there is no part of the body from which a man may not bleed if he has granular kidneys. We had carefully to consider this possibility in the case before us, and when the patient first came in we were inclined to think that chronic interstitial nephritis was not the cause of the hæmorrhage. In the first place, she was young to have granular kidneys, and, in the next, for the first twenty-four hours, the urine was normal in quantity, and without casts. Her arteries were not thickened, her blood pressure was not raised, there was no trace of œdema anywhere, and when we looked at the eyes we found no trace of retinitis albuminurica. For all these reasons we inclined away from the suggestion that her purpura was due to granular kidney. It is true that she had a little albumin in her urine, but many people with purpura have albumin in the urine quite independently of the presence of blood in it. I have here the kidneys in this case, and it will at once be seen that the patient had granular kidneys. I am not even sure now, however, that interstitial nephritis was the cause of the purpura from which she suffered. But the case will serve to remind you that granular kidneys are the cause of purpura. As the case developed under our observation it became increasingly likely that the kidneys were the cause of the trouble, because towards the end she had convulsions and a condition which pointed strongly to uræmia. To sum up with regard to this case and Bright's disease: for the reasons I have given, during the first twenty-four hours we did not think that the purpura was caused by granular kidneys, but during the later period, before the patient's death, it became quite probable that such was the case, as she developed obvious signs of uræmia.

With regard to the other causes in Mackenzie's list, it was evident that our patient had not got heart disease. It is not surprising that patients with heart disease have purpura, because there often is considerable venous congestion. Nor had our patient anæmia. If a person has extensive purpura because he is anæmic, it is almost certain that his case is one of pernicious anæmia. Scurvy, I suppose, occurs so often in the London Hospital because it is near the docks. I have never found a case at Guy's, although, from my previous experience at the Seamen's Hospital, I have been able to say definitely that certain suspected cases

Operation
for Feb. xiv.-
Cardioplasty.

were not those of scurvy. The disease is fast dying out. No case can be put down as scurvy unless the gums are very greatly swollen, and usually you find big intra-muscular hæmorrhages in the legs. A good many cases in Mackenzie's list are set down to starvation, and to the very weak and exhausted condition accompanying tuberculosis. Drugs account for three cases. The drugs that will produce purpura are iodide of potassium and large doses of chlorate of potash. The cases of poisoning from chlorate of potash belong to a time when it was extensively used; now purpura due to drugs is only seen in connection with iodide of potassium, and when it occurs as a result of giving the patient this drug, it shows itself as small hæmorrhages, mostly confined to the legs. The question of septicæmia in connection with our patient interested us very much. The woman had a raised temperature when she came in, and was shivering; judging from the state of her gums, for you will remember she had pyorrhœa, we thought she might have septicæmia, and I am not at all sure that her purpura was not due to that cause. As a matter of fact, after death, the *streptococcus longus* was cultivated from her blood. I am inclined to believe, therefore, that this patient's purpura was partly, at least, due to septicæmia secondary to her pyorrhœa, although I cannot deny that it may have been entirely due to the granular kidneys. The things that killed her were the convulsions and coma, which were certainly due to the uræmia. Whichever view is true, this case will help you to bear in mind that people with uræmia may have purpura. Congenital syphilis is another wasting disease, liable to produce a considerable degree of malnutrition, and thus to induce purpura; and the same remark applies to alcoholism. I do not quite know what Sir Stephen Mackenzie meant by "Convalescence," to which he puts down two cases. Leucocythæmia is easily distinguished, and in the same way the examination of the blood will show whether or not the patient has malaria. The extreme malnutrition due to rickets, again, will explain its inclusion among the causes of purpura. The one case for which whooping-cough is held responsible is far too low an estimate. I was resident for a year at the Evelina, which has a special whooping-cough ward, and I found that the violent paroxysms of coughing to which the patients were subject often led to rupture of blood-vessels in the skin, and so to purpura. Nor do I think that one case in two hundred represents the number of patients with purpura whose condition is due to cirrhosis of the liver. Probably in some cases the purpura was so slight that it was not considered worthy of note. In hæmophilia, for the bleeding to occur there must be a traumatic rupture of a blood vessel. In purpura the bleeding is spontaneous. I am, indeed, surprised that there is even one case of hæmophilia associated with purpura.

The list as given by Sir Stephen Mackenzie does not include some causes of purpura which are necessary to be remembered. The first one which I will add to it is "specific fevers." Of course, it would not be included in Mackenzie's list of the causes of purpura met with in the London Hospital, because specific fevers are not taken into a general hospital. I think that any eruptive fever may be sufficiently severe to cause purpura. It commonly occurs with small-pox; it may be associated with the malignant variety of measles. I have seen it in scarlet fever, and frequently in typhus. Another cause of purpura is jaundice. The presence of bile in the blood renders people liable to bleed. I remember seeing a jaundiced woman who had purpuric spots almost all over her body, some of them being larger than a five-shilling piece. She was pale from the loss of blood, and was deeply jaundiced. On the same day that I saw her she began to bleed from the vagina, and I got her admitted into the obstetric ward, but they could not stop the bleeding from the vagina, and she died of hæmorrhage. That was due, I suppose, to the jaundice. A serum-rash may also be purpuric. A man who came under Sir Alfred Fripp about two years ago had had given him for some surgical condition outside the hospital very large doses of horse-serum. He was covered with purpuric scarlatiniform rash, had blood in the urine, had a high temperature, and no one could have told, unless they had known that he had taken large doses of serum, that he was not suffering from scarlet fever. Henoch's purpura is another purpuric condition—a disease of children—the characteristics of which are purpura and paroxysms of abdominal pain. Still another cause that is not mentioned in Mackenzie's list is multiple sarcoma.

Now it will be noticed, on looking at our list, that in sixty-eight cases the purpura is unexplained. That is a very large number, and it brings me to the consideration of a disease that will be found described in the text-books as purpura hæmorrhagica—an atrocious name, because all purpura is hæmorrhagic. It has another name which is even more atrocious: morbus maculosus Werlhoffii. In this disease, of which you have all seen instances in the ward, the patient is admitted for purpura, and

no one of this long list of causes can be found to exist. The patient may also bleed internally and from the gums; he may have hæmaturia, and may even vomit blood. Sometimes such patients die from sheer exhaustion due to the loss of blood, at other times from hæmorrhage into the brain. The explanation of these cases is not known. If the purpura is slight it is called purpura simplex. The great majority of cases get well, but the bad cases are so severe as to prove fatal. Sometimes a slight temperature is present; sometimes albumin is found in the urine quite apart from the presence of blood. And it was the fact that some sufferers from purpura may have albumin without blood in the urine that made me consider in the case before us that the presence of albumin did not necessarily mean that there was anything the matter with the kidneys.

The treatment to be followed in those cases which can be assigned to a definite cause must, of course, be directed towards the cause itself. If there is no cause for the purpura, oil of turpentine is recommended. But I do not think that anyone who has had a wide experience of purpura would care to say dogmatically that oil of turpentine did good. You know that calcium salts increase the coagulability of the blood, and you may draw the inference that by giving them it should be possible to stop the bleeding, and they have been often given for purpura, but no increase of the coagulability of the blood will get at the root of the matter in purpura, for surely you cannot have purpura unless you have disease of the walls of the blood vessels, which lead to the formation of apertures in the vessels through which the blood corpuscles can pass. The essence of purpura must be something the matter with the walls of the vessels, or else the blood could not come through. It has been stated that the seat of the hæmorrhage in purpura is in the minute veins just at the point where they leave the subcutaneous tissue and enter the skin proper. They are especially weak at that point; hence they give way, and hence the purpura. In many of the cases in our list a weak vein would explain the condition. I pointed out that rheumatic purpura had its most frequent seat in the legs, and, of course, the venous pressure is greater in the legs than elsewhere. The backward pressure in heart disease would conduce to purpura for the same reason. Owing to the general lack of nutrition in tuberculosis and other conditions in our list, a little extra pressure would lead to the breaking of a minute vein at a very weak point, and all causes of purpura must in some way, we know not how, lead to such a weakening of the walls of minute vessels that they give way under the pressure of the blood in them. The essence of purpura, therefore, is that the vessels give way, and I do not think that a diminution of coagulability of the blood can have very much to do with it, although when once the blood has left the vessel it may cause the purpuric spot to be of some size. It has been recently shown that the coagulation of the blood depends upon so many factors that most of the observations previously made are practically worthless. The temperature of the air, the nature of the surface on to which the blood flows, and many other factors come into play—so much so that those who have lately especially worked with the subject distrust most of the previous observations. Then, again, it has been shown that although you may increase the coagulability of the blood by the addition of calcium salts outside the body, you cannot introduce into the body sufficient calcium salts to affect the coagulability of the blood in any way whatever. If we may judge by recent research, we are still in need of reliable observations upon the coagulability of the blood, and there is no clinical evidence as to any marked effect of calcium salts in this respect. I have given quantities of calcium salts for various forms of hæmorrhage, and I have not seen any certain improvement in consequence. Before you attribute benefit to calcium salts, reflect upon the frequency with which bleeding stops in those who have not had calcium salts given to them.

Appointments.

Royal College of Physicians of London.

On the nomination of the Council, Dr. NEWTON PITT was elected Bradshaw Lecturer for the year 1910, and Dr. A. E. BOYCOTT, Milroy Lecturer for the year 1911.

Admitted Members of the College on Examination, CHRISTIAN HUGO RIPPMANN, M.A., M.B. Cantab., and ERIC BELLINGHAM SMITH, M.D. Lond.

Civil.

HOLMAN, T. E., L.S.A., has been appointed District Medical Officer of the Uckfield Union.

LEEMING, A., M.B., B.S. Lond., L.R.C.P., M.R.C.S. Eng., has been appointed District and Workhouse Medical Officer of the Sudbury Union.

WOOD, T. N., L.R.C.P. Lond., M.R.C.S. Eng., has been appointed Resident Medical Officer to the Victoria Hospital, Burnley.

Guy's Hospital Debating Society.

THE Ladies' Night debate was held on February 12th. Dr. Shaw occupied the chair. The subject for debate was: "That in the opinion of this House the subject races of England should be given a greater share in the internal government of their countries."

Mr. MULLALLY, the proposer, complained that the wording of the motion necessarily included races such as the Red Indians, Hottentots, and Maoris. These had not asked for Home Rule, and were not worthy of consideration. His remarks would refer rather to the civilised races of India, Egypt and Ireland. These merely asked for a greater degree of control, and this was indicated by sentimental, economic and political arguments. A conquering race never fully understood the feelings of the conquered, who were susceptible to every slight, under the impression that the conqueror was full of contempt for them. All arguments were based on this feeling of wounded pride, to which a body of irresponsibles—known as agitators on the one hand, patriots on the other—would give expression, until, finding moral arguments of no avail, they resorted to arguments political in character. The aim of a Government should be the happiness and comfort of its people. No people, especially a conquered race, was happy if its wishes were disregarded, however rich it might be. Egypt did not need the healing of a wounded body, but that of a wounded pride. It was necessary for the conquerors to understand that their gods were not the people's gods. The agitators passed from pleading to threats, and eventually the movement was driven underground, with the result that a secret society, in itself a pernicious influence, was formed, the garrison increased, and so a vicious cycle established. The Nationalist movements could not be stopped; England must meet their demands half-way. With regard to India, the chaos found on the entry of the English had been due to the recent fall of the Mogul Empire. A condition of affairs had existed which would soon have righted itself. The disloyalty in India had been confined to parts directly under British rule. Ireland merely asked for control of internal government. Apart from sentimental reasons, they complained that their parliament had been taken away by bribery and treachery, and control of the exchequer by broken promises. Twenty-nine years of hard fighting had been necessary to gain Catholic emancipation, also promised at the time of the union. There was an unnecessary waste on officials, and no incentive to economy. There had been, and would be, loyalty under Home Rule. At present Ireland was at the mercy of any bidder.

Mr. BEVAN-BROWN, in opposing the motion, said that by increasing the strength of the subject races, England would decrease her own power. She may have erred in conquering these races, but once conquered they must be ruled absolutely. Rome had at first governed her colonies harshly; when the centre weakened, the colonies had usurped and become free. Native rule would cripple any attempts at reform and any chance of national prosperity which English rule might introduce. Egypt had herself called in the aid of England and France when financially crippled; the Egyptians did not desire self-government. Any increase of self-government entailed either an increase of native officialdom or an extension of the franchise, which would be disastrous where a diversity of races and religions existed. The hon. proposer had left out the Red Indians and Maoris for no other reason than to suit his own arguments. The Maoris were well represented; to give them a larger share in the government would be to raise them above the level of the English themselves. The hon. proposer had been too sentimental.

Mr. GOOL seconded the motion. He divided the subject races of the British Empire into two classes: those which had been reduced almost to extermination as a result of colonisation, and those which had been increased rather than reduced, such as India, Egypt, and Ireland. Increased government might mean government of the type by which the colonies are controlled, or complete nationalisation. The first was of no use to India. India was a country of historical greatness; many of the Indians were descendants of our own ancestors—the Aryans. To India was due a philosophy, literature, religion and drama displaying greater depth of thought and loftiness of imagination than that produced by any other country. The English had done comparatively little for India. Famines had increased—famines, not of food, but of money. During fifty years of English rule, money had been drained from the people by excessive taxation. This money had been spent on an Army to control the people, railways of none other than strategic value, unnecessary palaces, and inefficient schemes of irrigation. India clamoured for nothing so much as education. The Government had allowed on an average the sum of three halfpence per head for this purpose. If success in rule meant the happiness of the people, British rule had been a colossal failure. Indian culture, which had flourished under freedom, was being destroyed under oppression. The differences between Hindu and Mohammedan were not greater than those between Catholic and Protestant had been. The latter had been adjusted, as would have been the former had not England interfered. India did not require a Parliamentary government of its own, nor a hybrid government, combining the features of East and West, but rather a reversion to its ancient rule which might then be allowed to develop in its own way.

Mr. BILLING seconded the opposer. He objected to the sentimental attitude of the proposers. It was necessary to be practical and selfish, and govern to get the best advantage consistent with humanity. The hon. proposer's followers declared at one time in favour of a Republic, and at another in favour of Home Rule. The Irishman was selfish; the Englishman had a right to be equally selfish. The civilisation of India was worn

out and unfit for the twentieth century; such a procedure as the hon. seconder had advocated would be a retrogression and opposed to the laws of evolution. This speaker had entirely failed to prove that the famines he had mentioned would be relieved by Home Rule. The palaces of the Rajahs had been far more costly than those erected under English rule. Literature had been known to flourish at times of greatest stress. If England left India some one else would step in. The amount spent on education gave no indication as to its efficiency. No proof had been given that the welfare of the countries in question would be increased by any extension of self-government.

Mr. SANDISON said the Imperalistic mind had always appeared somewhat of a vague entity to him, and he was much interested in the examples of it which had been forthcoming in the course of the discussion. The seconder of the opposition had objected to the argument that sentiment played a part in international dealings, but how about "the hands across the sea" of which we heard so much from people of his way of thinking? England was, he pointed out, at the present moment, a subject race of Ireland, and we were appealing to them for a show of sentiment, just as they had done to us. In his opinion the race that declared itself to be a subject race was a subject race; it was not a point for the conquering nation to decide. It would not be possible to keep India by rigid rule. If the screw should be put on there was sufficient force in the country to overthrow English rule. Furthermore, as we extended education, so should we be willing to allow an extension of its practical use. As civilization advanced mutual toleration among nations would increase. With regard to Ireland, he pointed out that, though the Union had existed for 100 years, the condition had not been bettered comparatively, and there had been constant friction. Definite claims for extensions of local rule had been made. Should we not live up to our position as parents, and let the children have the latch-key for a night or two?

Miss STEBBING pronounced herself a vigorous opponent of Home Rule for Ireland, but declared herself in favour of self-government for India. Egypt was altogether exceptional, and other countries could be left out of consideration, seeing that they had not even a sufficient sense of responsibility to demand such a measure for themselves. India's position was entirely different. In her case we had a wonderful history and glorious traditions to consider, and an ancient civilization by the side of which ours was a mere mushroom growth. Her demands to be allowed to win back her old position were natural and just. She had been conquered in a fit of absent-mindedness, primarily by tradesmen. India was certainly unfit for a parliamentary government; East and West could never exist satisfactorily together. With the colossal impertinence of the occidental mind, Englishmen argued that a country was unfit to govern itself because it was unfit for government by Parliament. This alone showed England's utter ignorance of India and the impossibility of a just rule.

Mr. SELIM said that Egypt had nothing to do with the English races. The Khedive was appointed by Turkey; the official languages were French and Arabic; the English merely controlled the Army. England had been foremost in condemning the conditions of the Congo, yet, in deporting natives from their own country without trial, she had herself been guilty of the greatest crime on record. A conquered people before all others needed a liberal press, but although Tory and Radical were allowed to rage unchecked, India's press had been abolished. Justice never led to weakness. Let a country be governed with a rod of iron, but not with injustice. In the event of a German war with England, the Indians would rise to a man against our rule.

Mr. RYLE considered the English national temperament an effectual bar to any comprehension of the Indian's mind and needs. Into the administration of a rule so far distant abuses were particularly liable to creep. The possibility of individual and local repression had been increased by various legislative measures. The Indians were a fine race with fine traditions, and it was in England's power to destroy or encourage their further development, according as she continued or removed her influence from their midst.

Mr. WADE was struck by the manner in which the English speeches had failed as compared to those from members of the subject races. He had found no reason to believe that the English were heaven-born legislators, and instanced many shortcomings of their rule at home. England's success had been where her rule was light, as in Canada and South Africa.

Mr. SCHLESINGER, in a characteristic declamation, complained of the growth of socialistic influence in the hospital. He seemed to be under the impression that speakers had been advocating socialisation of the Empire. He had long desired to know what the Indians wanted; they did not know themselves. He lamented the sentimentality of the last speaker and of the Age, as instanced by vegetarianism and anti-vivisection. He referred to the "good old days," to which he desired a general return. He would like to see half the House decapitated. Increased government by the subject races entailed woman's suffrage. His speech was concluded by a profession of Imperialistic faith.

Miss RYLE said that those who rose to speak on behalf of Nationalism must be prepared to find themselves classed as "little Englanders." Such an accusation would, however, be unjust and contrary to fact. Nationalists upheld the maintenance of a united empire, but only when by so doing they did not simultaneously support militarism, political oppression and petty espionage on the one hand, and, on the other, compulsory loyalty and rebellion against authority. It was by the pursuit of semi-tyrannical methods that disintegration would ultimately be brought about. She instanced the Partition of Bengal, the Official Secrets Act, and the Seditious Meetings Act as examples of the methods by which England is slowly alienating herself from India. Nationalists were the true Imperialists, and, in spite of the paradox, unionism meant separation.

Miss G. STEBBING suggested that unsettled conditions at home were naturally the forerunners of unsettled conditions abroad. It was impossible for a modern civilization like ours to agree in ideas and ideals with an ancient civilization, such as India's. She herself was a staunch supporter of the Imperial idea.

Mr. BEVAN-BROWN, in reply, complained that his opponents had not made it sufficiently clear as to what they meant by self-government. It was his firm belief that scarcely any of our dependencies either wanted or were capable of governing themselves. England had wrought untold benefits for India, and Englishmen did not only go to India with the intention of getting the best out of the country. He repeated that his wishes were all for just rule, but that that rule must at the same time be firm and unflinching.

Mr. MULLALLY expressed regret that he should have met with so little opposition, and wished that the feelings of the House represented those of the country. An increase of strength among subject races meant also an increase of loyalty. He maintained that it was his duty as an Irishman to be disloyal to England only so long as his country was denied Home Rule. Sentiment, he urged, influenced nations as well as individuals. A country governed in a manner opposed to the opinions of its people was necessarily a subject country. England had not kept her promises to Ireland. He deplored the Imperialistic view as being narrow and incompatible with progress.

The House then divided. Result:—For the motion, 16; against, 15.

The meeting concluded with a vote of thanks to Dr. Shaw for taking the Chair, and the House then adjourned for refreshments.

Guy's Hospital.

DISPENSARY AND PHARMACEUTICAL LABORATORY REPORT FOR 1909.

The total number of Out-Patients who attended the Dispensary for Medicine during 1909 was 203,455, compared with 198,332 in 1908, 204,869 in 1907, 206,443 in 1906, and 199,974 in 1905; as will be seen from these figures the decline in the numbers in 1908 was of a temporary character. These Out-Patients are divided into those who pay the nominal sum of 3d. per week for medical supplies, and those who, pleading inability to pay this small amount, receive their medicine free.

The details for the last two years are given below:—

NUMBER OF DISPENSARY ATTENDANCES.

1908.	*Medical.*	*Surgical.*	*Casual.*	*Total.*
Paying	67,149	22,881	61,675	151,705
Free	7,831	3,827	34,969	46,627
Total	74,980	26,708	96,644	198,332
1909.				
Paying	66,436	25,437	68,499	160,372
Free	7,060	3,740	32,283	43,083
Total	73,496	29,177	100,782	203,455

An increase of 5,123.

These figures are interesting when compared with those of 1907. The number of Surgical cases is about the same; the number of Medical cases has decreased by about 10,000, which has been balanced by an increase of 10,000 in Casual or Surgery cases.

The following Table gives the amount of money received in the last two years:—

	1909. £ s. d.	1908. £ s. d.
Out-Patients	1,984 15 6	1,904 7 2
Sale of Drugs	113 3 7	94 16 10
Net Profit on Sale of Bottles to Out-Patients	92 5 4	76 18 5
Goods Supplied to the Medical School ...	105 2 3	65 1 6
Goods Supplied to the Dental School ...	44 19 11	46 5 10
Goods Supplied to the Institution	22 15 9	28 16 4
	£2,363 2 4	£2,216 6 1

In addition to the above, goods have been supplied to the various Departments to the value stated below:—

	1909. £ s. d.	1908. £ s. d.
Skiagraphic Department ...	10 10 7	19 11 9
Medical Skiagraphic Department	11 1 10	4 11 9
Electrical Department ...	4 19 0	6 15 5
Works Department	7 2 0	8 14 9
Laundry	1 7 0	1 1 6
	£35 0 5	£40 15 2

THE COST.

The total cost of Drugs and Dressings during 1908 and 1909 is given below from figures supplied by Mr. Williams, Clerk to the Governors.

	1909 £ s. d.	1908. £ d. d.
Drugs	2,773 0 0	2,526 0 0
Dressings	2,496 0 0	2,402 0 0
	£5,269 0 0	£4,928 0 0

This amount is £340 more than that of 1908, but for comparison it may be pointed out that the amount expended in 1907 was £5,159.

It may be of interest to place on record the fact that all the dressings are bought by contract. With regard to the drugs, the same system prevails in the case of those drugs for which the demand is regular, but in addition to these there are a large number which are only required occasionally, and the latter are bought from the contracting firm at a slightly reduced list price. The following gives the details for the last year:—

	£
Drugs (contracted for)	2,231
Drugs (no contract)	172
Proprietaries	87
Sera	116
Bottles, etc.	142
Labels	25
	£2,773

ANTISEPTICS.

	1909. Quantity used.	1908. Quantity used.	1909. Cost. £ s. d.	1908. Cost. £ s. d.
Acid, Boric ...	32 cwt.	22 cwt.	38 15 6	24 14 6
Acid, Carbolic	30 cwt.	20 cwt.	77 14 0	58 6 8
Chinosol ...	6 lbs.	4 lbs.	3 5 0	2 4 0
Cresol	280 gals.	246 gals.	19 11 6	16 18 0
Formaldehyde	650 lbs.	412 lbs.	11 12 3	6 16 10
Hydrogen Peroxide	485 gals.	245 gals.	50 7 5	27 2 8
Iodoform ...	28 lbs.	28 lbs.	16 5 6	16 5 6
Lysol	760 gals.	680 gals.	156 15 1	146 15 8
Mercuric Chloride	49 lbs.	56 lbs.	7 18 3	6 3 8
Mercuric Iodide	4 lbs.	8 lbs.	1 9 0	3 0 0
			£383 13 6	308 7 6

An increase of £75.

ANÆSTHETICS.

	1909. Quantity used.	1908. Quantity used.	1909. Cost. £ s. d.	1908. Cost. £ s. d.
Absolute Alcohol	566 lbs.	408 lbs.	118 13 5	62 3 11
Chloroform ...	756 lbs.	720 lbs.	55 10 4	52 14 8
Cocaine and its Salts ...	14 ozs.	16 ozs.	5 9 6	4 16 0
Ether	930 lbs.	1008 lbs.	91 16 6	89 8 7
Ethyl Chloride	204 tbes.	276 tubes	16 9 4	18 12 6
Eucaine Lactate ...	2 ozs.	2 ozs.	0 16 6	0 16 6
Nitrous Oxide	11,200 gals.	8800 gals.	18 3 0	16 10 9
Stovaine and other Spinal Anæsthetics	...	...	0 7 4	
			£307 5 11	£245 2 11

An increase of £62.

The increase in absolute alcohol is due to the fact that a larger amount has been supplied to the Pathological department of the Medical School. This is paid for by the Medical School.

It has been noted that there is an increasing demand for absolute alcohol in the theatres and in some of the wards. It is used to remove the last traces of water from instruments, etc. Arrangements have been made to return the liquid after use to the dispensary where the water can be readily removed and the re-distilled product employed in various ways.

DRESSINGS.

	1909. Quantity used.	1909. Cost. £ s. d.
Bandages, Grey	957 gross ...	457 9 1
Bandages, White ...	678 gross ...	442 0 6
Bandage Cloth	13,500 yards ...	85 15 8
Cellulose Wadding ...	224 lbs. ...	4 1 1
Felt	37 lbs. ...	10 14 8
Felt, Poroplastic... ...	2 sheets ...	2 7 10
Gauze, Double Cyanide ...	39,260 yards ...	109 4 6

DRESSINGS—*continued.*

	1909. Quantity used.	1909. Cost. £ s. d.
Gauze, Grey	33,110 yards ...	85 6 8
Gauze, Iodoform	16,000 yards ...	58 7 4
Gauze, Ribbon	37 doz. ...	12 3 3
Holland, Brown	20 rolls. ...	42 14 9
Lint	100 cwt. ...	489 10 11
Lint, Boric	34 cwt. ...	136 14 5
Compressed Moss ...	144 sheets ...	3 12 2
Mead's Strapping ...	28 doz. ...	21 15 4
Tissue, Gamgee	281 lbs. ...	9 10 0
Tissue, Gutta Percha ...	422 lbs. ...	74 1 9
Tow	8 cwt. ...	7 18 0
Wool, Absorbent ...	113 cwt. ...	294 19 2
Wool, Grey	31 cwt. ...	57 19 2
Wool, Sal Alembroth ...	6 cwt. ...	21 14 8
		£2,428 0 11

Great difficulty has been experienced in maintaining the supply of absorbent wool up to sample, and some of the deliveries have been rejected. To some extent this may be attributed to the very abnormal condition of the cotton market, and the consequent high price and shortage of raw material.

The following figures are of interest in showing the large amount spent on a few items :—

	1909. Quantity used.	1908. Quantity used.	1909. Cost. £ s. d.	1908. Cost. £ s. d.
Bismuth Salts	228 lbs.	168 lbs.	83 18 9	56 5 10
Camphor ...	330 lbs.	250 lbs.	31 1 0	33 13 0
Glycerin ...	36 cwt.	32 cwt.	120 0 0	102 4 0
Honey	38 cwt.	38 cwt.	53 16 3	51 18 5
Malt Extract	190 cwt.	170 cwt.	216 10 0	199 12 2
Opium and its Alkaloids	56 lbs.	56 lbs.	53 10 6	38 10 3
Potassium Iodide	282 lbs.	252 lbs.	107 14 10	98 17 6
Rectified Spirit	250 gals.	250 gals.	279 3 4	245 11 2
Methylated Spirit	1760 gals.	1440 gals.	164 4 6	100 17 4
Sugar	66 cwt.	54 cwt.	48 11 7	48 16 1
			£1,158 10 9	976 5 9

THE DUTY ON ALCOHOL.

This shows an increase of £182 in the cost of ten largely-used drugs not included under previous headings. With regard to the item Rectified Spirit, £34 of the increased cost is due to an increase in the Excise Duty. This amount represents the increased duty on 100 gallons only, which quantity has been bought since the introduction of the 1909 Budget. As it was estimated that there would probably be an increase in the duty on alcohol, as much as could possibly be stored was bought for the year's requirements before the Budget was introduced. The increased duty on 90 per cent. alcohol is 6s. per gallon, and this would have increased the expenditure on this article by £75 per annum.

PHARMACEUTICAL LABORATORY.

The work of this section has included the following:—

	1909.	1908.
Collodions	12 galls.	10 galls.
Confections	1 cwt.	1 cwt.
Dentifrice	3 cwt.	3 cwt.
Lotions	5,500 galls.	5,000 galls.
Liniments	300 galls.	230 galls.
Mixtures	9,000 galls.	8,440 galls.
Ointments	40 cwt.	35 cwt.
Plasters	5,000 yds.	4,000 yds.
Syrups	800 galls.	712 galls.
Compressed Tablets ...	800 lbs.	418 lbs.
Tinctures & Liquid Extracts	300 galls.	220 galls.
Soda Water	28,400 syphons	28,100 syphons

It will be noted that a much larger demand has been made for compressed tablets. In a great measure this is due to the introduction of a tablet containing Formaldehyde to take the place of an expensive proprietary tablet. After a large number of trials a formula was devised and submitted to the Medical Committee for approval. No less than 300 lbs. of these tablets have been used, and the cost of the ingredients has been £5. This quantity of the proprietary article would have cost £202, which would have been a prohibitive price as far as hospital work is concerned.

(Signed) HORACE FINNEMORE, B.Sc., F.I.C.
Pharmacist to the Hospital.

February, 1910.

Guy's Physiological Society.

A MEETING of this Society was held on Monday, January 24th, Mr. Kennaway being in the chair.

Mr. T. I. Bennett read an interesting paper entitled "Some Notes on Colour Vision."

The author first dealt with the nature and incidence of colour-blindness, since it is from the latter that most theories of colour vision have been evolved. There is a good deal of evidence to show that colour-blindness is inherited, according to Mendelian laws, and although the anomaly is more commonly found in men, it is usually inherited from the mother. Thus it may be said that the character is dominant in males, recessive in females.

According to the Board of Trade and other statistics, quite 4 per cent. of the population suffer from some form of colour-blindness.

The Holmgren test is the one which has been generally used until quite recently, but it has proved most unreliable and is now being superseded by that of Mr. J. Edridge Green, who, using his own system, has been able to make a very complete classification of the colour-blind. The author then proceeded to deal with the various theories of colour vision, and concluded that the Young-Helmholtz theory agreed best with the work of Edridge Green.

A paper entitled "Voluntary Movement" was read before the Society by Mr. G. S. Miller, on Monday, February 7th, Mr. Leeming taking the chair.

The author wrote his paper in support of what he called "the automaton theory of the physical basis of mind"; a theory which maintains that consciousness—so-called will—has no power over our cerebral processes and our actions. In support of this theory he mentioned that a nervous impulse was carried along from neuron to neuron by the dendrites and axons until it found a termination in a peripheral end organ, and that, except by the increase in the number of possible paths available for the impulse, there is no difference between the higher and lower central nervous system, and that every action is merely a reflex, and is impossible without some external stimulus entering by an afferent path. He denied that impulses can be generated in the brain by consciousness or will. He gave the results of cutting the cord of animals at different levels, the reflexes becoming more complicated as more of the cord was left intact. He explained this by saying that the higher in the nervous system the impulse can travel the greater number of paths are available, and consequently a more complicated movement may result.

The phenomenon of sleep-walking was also given as an example of a complicated act in which the consciousness could play no part. A case was quoted in which a student worked a mathematical problem in his sleep, which he had failed to do whilst awake.

Consciousness was said not to have any influence whatever over ordinary physical processes. The relation of consciousness to physical processes according to this theory was not yet explained,

In the discussion which followed, seven members and the chairman took part. The discussion showed considerable disagreement with the theory put forward.

Chapel Notices.

THE following Special Services will be held during Lent on Thursdays, at 8.15 p.m.:—

February 24th.—Preacher: Rev. A. Boyd-Carpenter, Rector of S. Olave's, Hart Street, E.C.

March 3rd.—Preacher: Rev. W. J. Conybeare, Rector of S. Mary's, Newington, S.E.

March 10th.—Preacher: Rev. A. H. Stanton, S. Alban's, Holborn, E.C.

March 17th.—Preacher: Rev. Pearkes, St. Agnes', Kennington, S.E.

The Holy Communion will be celebrated during Lent on Tuesdays, Thursdays and Fridays, at 7 a.m., and on Wednesdays at 8.45 a.m. Evensong will be said daily at 5 p.m. The Chapel is open from 7 a.m. to 10 p.m. for private prayer and reading.

PERIODICALS RECEIVED.—The Hospital; The Clinical Journal; The Nursing Times; St. George's Hospital Gazette; The Middlesex Hospital Journal; The Prescriber; St. Thomas's Hospital Gazette; My Journal; The Manchester Medical Students' Gazette; South African Medical Record; The Polyclinic; London Hospital Gazette; St. Bartholomew's Hospital Journal; Prince Alfred Hospital Gazette.

Dental News.

At a clinical meeting of the Dental Society, held on Friday, February 4th, Mr. H. P. Aubrey, the President, being in the chair, the following cases were shown :—

Recurrence of an osteo-fibroma arising from the right maxilla. The President and Mr. Edgar.

Dentigerous cyst in the lower right premolar region. (A tooth with fully-formed crown had previously been removed.) Mr. R. W. Powell.

Fracture of mandible showing splinting by Gunning's method. Mr. R. W. Powell.

Epithelioma of the floor of mouth. Mr. F. Bocquet Bull.

Excision of the superior maxilla, leaving intact the alveolar border. Mr. F. Bocquet Bull.

Rodent ulcer. Mr. F. Bocquet Bull.

The last two cases were under Mr. Symonds, to whom the thanks of the Society are due for allowing their presence.

The following members, amongst others, joined in the discussion which followed :—The President and Messrs. Barnett, Messinier, Neft, Ollis, Patel, Samuels, and Saul.

Mr. H. H. Glover brought forward as a casual communication a portion of alveolus, showing the lateral incisor in position, together with the socket of the central incisor. The central incisor was loose, and the patient had removed it with his fingers. Three weeks later the portion of alveolus came away. The front walls of the two sockets being absorbed, the question arose as to whether the cause was pyorrhœa alveolaris.

Hearty congratulations are tendered to Messrs. J. R. Palmer and H. Gordon Spain on their recent appointments as Civilian Dental Surgeons to His Majesty's Naval Forces. They have already taken up their duties—Mr. Palmer at Shotley, and Mr. Spain at Deal. As far as Guy's is concerned this is a most satisfactory result, as applications for these two appointments were submitted to the Admiralty by many late students of the London and Provincial hospitals.

The attendance of patients in the Conservation Room for the past six weeks is as follows :—

Week ending January	12th	605
" "	19th	601
" "	26th	663
" February	2nd	685
" "	9th	701
" "	16th	706

This makes interesting reading, as existing records show that previous to these dates there was no weekly attendance reaching 600.

Guy's Dental Society Dinner.

The Fifteenth Annual Dinner of the above Society was held in the Empire Rooms, Trocadero Restaurant, on Saturday last, February 12th. The President, Mr. H. P. Aubrey, occupied the chair, and presided over a most successful and enjoyable gathering. We understand that the dinner was a record one as far as numbers are concerned; no less than 197 members and visitors were present, last year's record of 152 being thus well beaten. This year there has also been a record average attendance at the ordinary meetings of the Society, a result which must afford much gratification to the officers of the Society, and especially to Mr. S. Wilson Charles, its honorary secretary.

Among those present at the dinner were :—Dr. Fawcett, Mr. Patterson, Mr. Underwood, Mr. Hallett, Mr. Douglas Gabell, Mr. Rowlands, Mr. Robbins, Mr. A. R. Thompson, Mr. Layton, Dr. Cock, Editor of the *British Dental Journal*, Editor of the *Dental Record*, as well as Mr. Maggs, Mr. Wynne Rouw, Mr. Hopson, Mr. Lewin Payne, Mr. Dowsett, and Mr. Pearce.

An innovation at the dinner, which was much discussed and criticised, was the abandonment of speeches. We shall probably be reflecting the general feeling by saying that we think it would be well in future years to strike a happy medium in this matter by having a few speeches, but not the lengthy list of former years. Last year some of the speeches were so excellent that many who were present this year felt that it was a pity not to hear some of the speakers again.

In place of speeches an entertainment was given during the course of the evening by Miss Alice Elieson, who sang to her own 'cello accompaniments; Mr. A. Ulph Smith, who gave some humorous sketches at the piano; and Mr. Walter Churcher, whose comic recitations were highly popular.

At the close of the dinner, Mr. Hopson briefly proposed the health of the President, and Mr. F. B. Bull that of the secretary, both toasts being received with acclamation.

Sport.

Rugby Football.

GUY'S v. UNITED SERVICES.

Played at Honor Oak Park on Saturday, February 5th, on heavy turf, which rapidly became worse as the fine rain in which the match commenced became heavier. The Services were not able to bring their strongest side, but the team that put in appearance were quite strong enough to beat the Hospital by 6 points, 1 penalty goal and 1 try to nil. Guy's did not play well on the mud, and just at present the forwards have lost form, doubtless a temporary failing only, but in view of the approaching Cup Ties it is much to be hoped that they will soon play up to the high reputation which they earned before Christmas.

The Services played against the wind during the first half, and relied almost entirely on footwork. Lieut. Harrison, well assisted by Lieut. Abercrombie, was in the forefront of all the Naval attacks, and Guy's were hard pressed to keep them out. Slowly Guy's worked back, but it was hard fighting all the way; the movement closed by the ball being punted over the line, and Hoby just failing to reach it before Lieut. Edwards

touched it down in defence. At half time, therefore, the score sheet was blank.

Resuming, only a few minutes had elapsed before Archer had to retire; he damaged his side rather badly, and for the rest of the game his very valuable services were lost to the team. Still the Services pressed, although in the "scrums" with only seven men the Hospital held their own. In the loose work the United Services were much the better, and whether with the ball on the ground, or attempted passing, they were always the more aggressive. An offside ruling against Guy's opened the scoring, Harrison with a fine kick landing a penalty. Stringer came very near equalising shortly after, he almost ran round Edwards, and though he did not quite clear, it was a great effort. After this Guy's had to defend again, and a series of tight scrums in the home 25 resulted in passing bouts, from one of which Royle ran over the line with a try which Harrison did not convert. Final score, Services, 6 points; Guy's, nil. Team:—

GUY'S.—G. E. W. Lacey (back); L. B. Stringer, H. Lee, A. H. Harkness, A. L. Stokes (three-quarters); J. G. Saner, C. H. Medlock (halves); H. R. Mullins, H. Archer, W. E. Williams, A. H. Crook, G. R. Hind, H. Hoby, C. S. L. Roberts, W. S. Stranack (forwards).

REMARKS.—The team as a whole were disappointing. They never approached true form, or anything like it. Lacey and Stringer were good, the latter excellent, in fact. Lee was a little slow, Harkness was sound, but lacked initiative. Stokes did not appear to put his "soul" into it. If a high punt is never likely to find touch, it should be followed up as a rule by the kicker with all his pace; the catcher may miss it, especially on a greasy day. Stokes punts high and well, and should follow up at top speed. Saner and Medlock should both try to avoid punts which the full back can reach and clear with ease. If one cannot pass or go on, find touch. The forwards did not use their feet half enough; it was a day for feet first, last, and always. Much of the tackling by the forwards, with two exceptions, was too high. There was no thoroughness about the work. The opponents slipped the hold and went on repeatedly. The pack lacked "devil," and must find some before the Cup Ties.

GUY'S v. LONDON WELSH.

A good crowd turned up on the hospital ground last Saturday to witness this return fixture, for which the visitors turned up two short, but efficient substitutes were found in Tweed and Gibb, who played a good game and did their utmost for the side that had impressed their services.

General regret was expressed at the absence of the Guy's captain; the many present, who had seen him play so many times, and had but recently heard of his illness, were very anxiously sympathetic. But the encouraging reports of his condition that were brought by men coming down from the hospital relieved the general feeling of anxiety which, it is safe to say, almost all present felt. May his recovery be speedy and complete.

The London Welsh played from the gate end for the first half, but there was no advantage much either way, although later in the afternoon the sun was a little troublesome to the side playing from the factory end of the field. The ground was soft, but better than the last two Saturdays. Dr. Leonard Stokes took charge of the whistle, and thanks are due to him for so kindly officiating. The Referee's Society seldom appoint men on a day when an International is being played, so that Dr. Stokes' services were much appreciated by players and spectators. It was early evident that the return of Mr. Jones to the side was going to make a big difference. He played splendidly himself, and with that great knowledge of the game which he possesses and imparts, the side were kept at concert pitch throughout. But the Welsh scored first; Evans was the try-getter, after loose forward play. No goal resulted. Play was gradually getting further into the Welsh quarters, where fine passing left the ball with Stokes, and a return pass to Lee saw that player gain a try. Moberly scored cleverly just after. So that, neither try being added to, half time was taken with Guy's leading by 6 to 3.

Resuming, Guy's played well. Roberts was on the ball perpetually; Kennedy a good second, the others all doing their share. Ultimately a typical lightning dash by Stringer ended with a try beneath the bar. Next came passing all along the line, from Medlock to Stringer, Jones, Lee, and last to Stokes, who scored. Roberts next got a good try. Kennedy also finished an admirable afternoon's work with another. Only one try was converted, Hind goaling Stokes' try. The final score read: Guy's, 1 goal 5 tries (20 points). London Welsh, 1 try (3 points). Team:—

GUY'S.—G. E. W. Lacey (back); L. B. Stringer, H. Lee, J. P. Jones, A. L. Stokes (three-quarters); J. G. Saner, C. H. Medlock (halves); G. R. Hind, W. E. Williams, A. H. Crook, H. Hoby, C. S. L. Roberts, A. V. Moberly, R. S. Kennedy, V. Glendining (forwards).

REMARKS.—A good win, and quite deserved. The side showed much more dash and all fulfilled their respective parts admirably.

GUY'S v. CAMBRIDGE UNIVERSITY.

The Cup Tie following the day the above match was played at Cambridge prevented the full side going down to the University town. About eleven of the first XV. were away. Those reserves, however, who turned out did much better than is indicated by the score of 27 points to 8. The forwards were quite useful, and Roberts, as usual, was in great fettle. Cambridge had Atkinson and Boyd away; otherwise the side was made up of "Blues." A strong wind blew right down the ground, the Cantabs playing for the first half with this advantage. Two minutes or so from the commencement of play, Pyman, Jones, and Purves put in some passing, the last named going over with a try, which Mann converted. Immediately after Hoby scored for Guy's, but Moberly's attempt at goal failed. The Cambridge men replied with another score; Marburg gaining a try. This was not added to, and for some time Guy's were somewhat pressed. Reynolds eventually added a third try, which Mann missed converting. Before half-time Chapman scored for them, Lockhart converting from an easy position.

The "Blues" had to defend more during the second half, as Guy's had the advantage of the wind; only a few minutes had elapsed before Lacey intercepted, and Kennedy goaled. Soon, however, Cambridge forged ahead again, Purves falling over the line from a line out. Guy's were more aggressive for a bit, but sound defence

kept them out, and before the end MacGregor and Lockhart added further tries for Cambridge, one of which was added to by Reynolds, the final score reading: Cambridge, 3 goals 4 tries (27 points); Guy's, 1 goal and 1 try (8 points). Team :—

GUY'S.—H. Millett (back); C. H. Medlock, G. E. W. Lacey, J. P. Jones, A. H. Harkness (three-quarters); P. J. Monaghan, C. B. Pritchard (halves); A. V. Moberly, H. Hoby, C. S. L. Roberts, R. S. Kennedy, V. Glendining, C. Gibb, T. D. Stout, W. Turnbull forwards).

Association Football.

UNITED HOSPITALS v. STADE LORRAINE, AT NANCY.

The United Hospitals team journeyed over to Nancy on Saturday, February 5th, leaving Charing Cross at 9 a.m., and arriving in Nancy at 11 p.m., where they were received by several hundred people. As regards the football, two matches were played.

On Sunday, February 6th, the Hospitals won easily by 14 to 0, and considering the terrible condition of the ground, and the pouring rain, this result was exceptional.

On Tuesday, February 8th, the ground previously played on was under about twelve to eighteen inches of water, due to the rise of the river Meurthe, which runs within thirty yards of the top end. Some of our opponents had actually rowed over it on the Monday morning. Thus our opponents had to find another ground, and such a ground it was that it would be gross flattery to call it anything else than a series of water pools, joined together by gravel and bricks in some places, and in others by six inches of sawdust. However, despite these terrible conditions, a match was played, again in pouring rain, and won by 5 to 0.

It is difficult to remark upon the play itself, but one thing strikes one forcibly, and that is, that the French team has a future before it, if only the members will realize that in football the aim is to go straight for goal and score, instead of making scientific passes until the ball is eventually taken from them.

Our opponents' defence was, considering, very good, but Bergh, Waugh, Henderson & Co., were far too clever at dribbling.

The onlookers seemed to delight in the number of goals scored, and a crowd of about 600, who watched the first match in a pouring rain, was increased to over 1,000 for the second game, when the conditions, were, if possible, worse than before. Apart from the football, every member of the hospital's team admits that he has had the "time of his life." To fully detail all the fêtes and receptions would take up far too much room, but if our royalty had been received as well as the hospital's team, they could not find fault with either the arrangements or receptions, and I, for one, can join in most heartily with our French friends and say, *Vive l'entente cordiale!* Team :—

UNITED HOSPITALS.—E. A. Brock, Bart.'s (goal); H. R. Bastard, Guy's, N. F. Norman, Bart.'s (backs); M. E. Vlasto, University, P. A. Wish, Bart.'s, P. S. Humm, Guy's (half-backs); R. M. King, Guy's, A. A. Henderson, University, A. S. Waugh, Bart.'s, V. E. Bergh, Guy's, R. M. Barrow, Bart.'s (forwards). Reserve: Nash Wortham, Bart.'s.

GUY'S HOSPITAL v. REIGATE PRIORY.

(INTERNATIONAL TROPHY DU NORD.—SEMI-FINAL.)

The Hospital met Reigate Priory, for the second time this season, in a cup tie. On the home ground the Hospital beat Reigate by 1–0 in the Surrey Cup Tie, but in the above competition drew 1–1 at Reigate.

The Hospital team was somewhat lucky to make a draw, and yet unlucky in not winning, since the Reigate team were rather better on the whole, but if the Hospital had accepted at least one of the three undoubted chances which came their way, the result would have been a win. The ground was in perfect condition, and a fair muster of supporters surrounded it.

Losing the toss, the home team chose to play uphill, and from the first set up a strong attack, Rook having to clear several times in the first fifteen minutes. From some good midfield play the ball was taken into our opponents' territory, where Humm was pulled up for offside when in a good position. A little later Bergh and Birks, after a good dribble, set up a good attack, but nothing resulted. Reigate replied, and only Rook's brilliant saves prevented a score. From a pass out to Humm, who swung the ball across the goal-mouth, King was able to open the score. Shortly after, two grand opportunities of scoring occurred from centres by King, which were missed completely by Bevis, Bergh and Birks in turn, and Humm, who managed to gather the ball, failed to score.

After half-time, the Reigate team set up an almost continuous attack for some time, and eventually, despite the efforts of Bastard and Keer at back, they scored from a corner. No further score resulted, each end being visited in turn, and the game came to an end as stated. The replay takes place at Honor Oak Park. Team :—

GUY'S.—H. C. Rook (goal); H. R. Bastard, K. J. T. Keer (backs); H. B. Neely, J. Kyle, V. Golledge (halves); R. M. King, S. Bevis, V. Berg, A. H. Birks, P. S. Humm (forwards).

REMARKS.—The result was very satisfactory, as Reigate Priory are exceptionally strong on their own ground; there are still many weak points in the Hospital team. Bevis is still very slow in getting going, and in tackling or intercepting. Berg and Birks will be a strong combination when more accustomed to each other's play. Golledge must learn to support his forwards more. Kyle is greatly improved, and, with Neely, Bastard and Keer, formed a really strong defence. Rook was good and very safe, and seems to be getting over his temporary staleness.

[Several reports of matches are unavoidably held over through lack of space.—ED.]

Birth.

HOLMAN.—On January 14th, at 6, Thornhill Road, Croydon, the wife of A. Edgar Holman, L.D.S., of a son.

Marriage.

FULLER—KEMPFF.—On February 3rd, 1910, at the Royal Naval Church, Stockholm, Sweden, by the Rev. Emil Gemzell, Swedish Court Chaplain, Frederick Holcombe Fuller, M.R.C.S., L.R.C.P., L.D.S., to Ester Anna Antoinette, second daughter of Captain Govert Kempff, R.N., and Mrs. Kempff, *née* Gondret.

ED.—A. N. C.

GUY'S HOSPITAL GAZETTE.

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Calendar of Coming Events and Ensuing Take-in Weeks.

March.

Sat. 5. 1st XV. v. Lennox (Away).
2nd XV. v. London Scottish "A" (Away).
1st XI. v. Surbiton Park (Away).
2nd XI. v. Horton Asylum (Away).
Debating Society's Meeting postponed.
Inter-Hospital Boxing, Fencing and Gymnastic Competition, 8 p.m.

Mon. 7. Clinical Lecture by Mr. Ormond (Ophthalmology), 1.15 p.m.

Wed. 9. Examinations for the Junior Prizes for General Proficiency for the Michael Harris Prize and the Sands Cox Scholarship begin.
Inter-Hospital Rugby Cup Final Tie, Guy's v. London, Richmond.

Thur. 10. Examination for the Golding-Bird Gold Medal and Scholarship begins.
Messrs. Dunn and Rowlands' Take-in (Messrs. Lucey and Johnston).

Sat. 12. 1st XI. v. 3rd Kent Artillery (Away).
Debating Society's Meeting, 8 p.m.

Mon. 14. Clinical Lecture by Dr. Hertz (Electrotherapeutics), 1.15 p.m.
Physiological Society's Meeting, 4 p.m.

Wed. 16. Physical Society's Meeting postponed.

Thur. 17. Sir Alfred Fripp and Mr. Turner's Take-in (Messrs. Lee and Duvivier).

Fri. 18. Physical Society: Final Meeting of Session, Dr. Hale White in the chair, 8 p.m.

Passim.

ON Wednesday next, at Richmond, our annual Rugby contest with the London Hospital is to take place once more. In the semi-finals London beat St. Bartholomew's by only 5 points to nil, and Guy's beat St. Thomas's by 22 points to 5 on Thursday last. If anything like the same weather conditions obtain next Wednesday, there ought to be a large crowd to watch the final. In any case an interesting and closely-contested game may be expected.

THE following appointments have been made by the House-Committee:—To be Ophthalmic House-Surgeon, Mr. H. G. Rice; Obstetric Resident, Mr. W. Johnson.

WE are asked by the secretaries of the societies to announce that the final meeting for this session of the Physical Society, when Dr. Hale White will take the chair and the Treasurer's Prize Essay will be read, has been postponed from the 16th to the 18th of this month; and that the final meeting of the Debating Society has been postponed from to-night to next Saturday, the 12th.

READERS who have not seen the hospital lately will not be surprised to hear that changes in the buildings are still proceeding, and very much more extensive changes and additions are likely to be seen in the near future. Among the minor alterations we may mention that the old Dressers' Rooms overlooking the front quadrangle, and a room formerly occupied by the GAZETTE, have been adapted for the accommodation of nurses: this has been necessary owing to the increase in the nursing staff. A further increase in the accommodation for nurses is to be provided for by the extension of the Nurses' Home over that half of the medical school buildings which adjoins it. The present Physics and Chemistry laboratories are to become part of the Dental Department, and new laboratories for these sciences will be provided by the completion of

the Medical School buildings above the Physiological Department. Two new floors are thus to be added to each wing of the Medical School buildings, and the main entrance is to be properly completed, so that the appearance of the building, somewhat incongruous in its present state, will be much improved.

In the hospital itself changes are also occurring. The conversion of the old Front Surgery into an Actinotherapeutic Department is practically completed, and this will be opened for the treatment of patients very shortly. The new surgical X-ray room at Out-Patients is also now complete and in use. A scheme has been approved by the Governors for the conversion of the present Light Department on the top floor into a new suite of Operating Theatres. The plans provide for three new theatres, lighted from the top and sides, with galleries for onlookers, and smaller rooms adjoining for the administration of anæsthetics. The latter is a very desirable feature, and its absence from the existing theatres is frequently commented upon by visitors. In addition there are to be sterilisation and preparation rooms, and a room for the pathological examination of specimens, so that the diagnosis of tumours, etc., removed can be quickly made on the spot by microscopic sections. There is no more striking proof of the advance of surgery during recent years than the increase in the number of our operating theatres at Guy's. Eighteen years ago, one theatre supplied all the needs of the institution; at the present time the number of theatres cannot be counted on the fingers of both hands; and very shortly, as we have indicated, the number is to be still further increased.

With all these changes and additions, there are still some more we should like to see carried out. One crying need in the hospital is the provision of a clinical laboratory worthy of the name in connection with the medical wards. The little room at present dignified by that title is so extremely inconvenient and ill-equipped that the simplest laboratory process carried out in it involves an expenditure of time and trouble quite out of proportion to its importance. It is a striking example of the English attitude towards clinical research, and towards laboratory work in general, for the same attitude is to be found in English commercial concerns. Where one analytical chemist is employed by an English firm, probably six are employed by a German firm in the same line of business, and it is obvious that this increased expenditure in salaries must be more than justified by increased profits due to these laboratory investigations, or it would not be incurred. To us, as a nation of shopkeepers, it might be thought that these commercial advantages would appeal, but since they do not, it cannot be expected that clinical research, with no financial advantages to offer, should be appreciated and endowed.

After the provision of a proper clinical laboratory we should like to see adequate accommodation made for the bound volumes of clinical reports, so that research among these archives might become a somewhat less tedious, dirty, and inconvenient occupation than it is at present. It may be said that the most valuable researches have sometimes been carried out under the most disadvantageous conditions, and that is quite true; but we maintain that it has been in spite of, and not because of, those conditions. Good scientific work has been done in such surroundings as garrets and disused tramcars, no doubt, but better work, and more of it, might be done in properly-equipped laboratories. We therefore hope that a clinical laboratory and a library for clinical reports, worthy to be shown to visitors, may some time be established here, and we anxiously wait for the time.

We record with deep regret the death of an old Guy's man, Dr. Thomas Kilner Clarke, Surgeon to the Huddersfield Infirmary. Dr. Clarke died on February 14th, in his sixty-seventh year. He qualified in 1871, after studying at Cambridge, Paris, and Guy's. In the following year he became a F.R.C.S., succeeded to his father's practice at Huddersfield, and began to specialise in surgery, receiving the appointment mentioned above. He became one of the most successful abdominal operators in that part of the country, and in later years he gave up general practice for consultant work. In 1903 he was appointed a J.P. for the Borough of Huddersfield. His relaxations he found chiefly in shooting, fishing, and hunting, and as a lover of horses he became President of the Huddersfield branch of the Royal Society for the Prevention of Cruelty to Animals.

The Functional Examination of the Auditory and Vestibular Apparatus.

By W. M. Mollison, M.A., M.C.
(Arthur Durham Travelling Student.)

Part II.—The Vestibular Apparatus.

The anatomy of the vestibular apparatus (or labyrinth) must be shortly recapitulated, since it has an important bearing on the subsequent question of labyrinth stimulation. The vestibular apparatus is contained in a bony capsule; this capsule consists of three parts: the vestibule, the bony semicircular canals and the cochlea. In the vestibule and semicircular canals is found a membranous labyrinth corresponding more or less closely to the bony capsule. In the vestibule are found the saccule and utricle; and in the bony canals lie the membranous canals, not filling these canals, but supported in them by connective tissue strands. Between the bony and membranous labyrinths lies a fluid—the perilymph—and inside the membranous labyrinth lies the endolymph. The membranous labyrinth is lined by an epithelium, which in certain parts is thickened; these thickenings are due to certain specialised cells with hair-like processes in direct connection with filaments of the vestibular nerve. Lying above these cells is a viscid fluid containing in it small bodies, or otoliths. Any movement of the head produces movement of the fluid in the canals, and tends, therefore, to bring the otoliths in contact with the hairs of the special cells, which in turn stimulate the fibres of the vestibular nerve.

Now the labyrinth may be looked upon as an organ governing the equilibrium and co-ordination of the body, and as a "sense organ," in that it contains specialised sensitive cells in connection with a nerve which passes to the central nervous system, but it differs in a striking manner from other sense organs. Contrast the labyrinth with the auditory apparatus; every stimulation of the auditory apparatus is appreciated by the patient, while stimulations which are constantly affecting the labyrinth are not so appreciated. Expanding this a little further, sounds can be heard by the patient, and differences between various sounds noted, and, when the perceptive apparatus is defective, the patient notices that sounds are not heard as before; further, this defect—deafness—is referred by the patient to the ear.

In the case of the labyrinth, on the other hand, the patient does not appreciate the fact of the co-ordination which results from labyrinth stimulation, and certainly does not attribute it to the organ in question.* Moreover, when the apparatus is defective, and the patient has loss of co-ordinating power, he does not refer this defect to the labyrinth.

Thus it is obvious that the examination of the labyrinth function will have to be conducted on different lines from that of the auditory apparatus.

As an introduction it is essential to consider briefly the results of a labyrinthine defect on the patient, for, though he cannot localise the defect, he suffers from very definite symptoms. The symptoms commonly complained of are: loss of co-ordination, vertigo, vomiting.

It is not proposed here to consider these symptoms further than is necessary for the discussion of the testing of the labyrinth, but suffice it to say that vertigo is the symptom most frequently complained of; moreover, this vertigo may be present in very varying degree, at one time of such severity as to cause the patient to fall suddenly to the ground, at another, of such insignificance as scarcely to disturb him.

It is clearly impossible to estimate degrees of *vertigo*, and equally so to obtain a standard by which to compare abnormal cases. Similarly, differences in degree of *loss of co-ordination* cannot be measured. Some other means, therefore, must be sought with which to compare one labyrinth with another. This means is found in a sign always present with vertigo; this sign is *nystagmus*.

A simple experiment to prove that nystagmus accompanies vertigo is made as follows:—Sit in a revolving chair with shut eyes and the chin sunk on the chest, and turn round in the chair three or or four times at a moderate rate of speed. Now stop and quickly look up and observe that some vertigo is experienced (the amount depends entirely on personal idiosyncrasy); and note that this vertigo is accompanied by jerking movements of the eyes to one side or the other (the direction of the movements depends on the direction of the turnings); further that the sense of vertigo is greatly diminished by looking to one side, and increased again by looking to the other.

Nystagmus, being thus easy of observation, is used to measure the irritability of the labyrinth. The scheme for the functional examination of an aural patient has already been

* It must not be forgotten that the labyrinth is assisted in the performance of its function by other sense organs, *e.g.*, the eye, sense of touch, muscle sense.

given in the discussion of the functional testing of the auditory apparatus; and as part of that scheme were added the various examinations to be made for the functional testing of the labyrinth. These points may be recapitulated—

Spontaneous nystagmus.
Disturbances of equilibrium.
Nystagmus after rotation.
Caloric nystagmus.
Galvanic nystagmus.

Before proceeding to describe these different examinations, it must be stated that under various conditions the irritability of the labyrinth may be increased or decreased, and that the change may affect one or both labyrinths. Moreover, the degree of irritability varies enormously in normal persons, a point which deserves great attention when the results obtained from the examination of a patient are being considered.

1. The first examination is for the presence of *spontaneous nystagmus*. By this is meant nystagmus which is present without any definite stimulation of the labyrinth; it may be very simple of observation, or of so low a degree as to be difficult to detect. Further, it is rotatory in character, a fact which greatly assists in its observation; for if, when the patient looks towards the side, the small horizontal vessels on the conjunctiva are watched, it will be seen that they jerk upwards or downwards, the direction depending on the side to which the patient is looking; these vessel movements are easier to notice than slight movements of the whole eye-ball. Within fairly broad limits the degree of nystagmus indicates the intensity of the labyrinth disturbance; a highly irritative labyrinth gives rapid and wide excursions of the eye-ball, and *vice versa*. The direction of the nystagmus is not constant; it may be towards the affected side or away from it; in the severe degrees of labyrinthitis it is directed towards the affected side.

When examining an aural patient it must be remembered that labyrinth abnormalities are not the only cause of nystagmus; many other diseases give rise to it as well. The following is a simple example: a patient, 40 years of age, suffering from chronic discharge from both ears, complained of vertigo; on examination he exhibited slight but definite nystagmus, thus suggesting labyrinth involvement; further examination, however, revealed all the signs of an early disseminated sclerosis.

2. Now follows the examination of the patient for *disturbances of equilibrium*. It has already been stated that the patients themselves may notice this; but when only slight degrees of loss of equilibrium are present special examination is needed. The following are those most commonly used:—(*a*) Romberg's sign. The patient stands with feet together and eyes shut; abnormal swaying movements or, in some cases, inability to stand, indicate loss of co-ordination. (*b*) Patient is made to walk backwards and forwards with eyes shut; this is almost impossible with loss of co-ordinating power. (*c*) Patient is made to stand with one foot directly in front of the other; it may be found that with the right in front the patient can stand steady; with the left in front he cannot do so. (*d*) The patient is made to stand on one leg and hop; this is a very searching test. This examination of the condition of the equilibrium and that for spontaneous nystagmus inquire into the question of abnormal labyrinthine sensibility, and now follow the tests actually applied to the labyrinth in the form of definite stimulations. These tests have as their object the discovery of change in the irritability of the labyrinth.

3. Of these three tests *Rotation nystagmus* is the first. This test is merely an expansion of the experiment already cited. The patient is seated in a chair which rotates about a vertical axis; this chair is provided with arms for the patient to grasp, and has a head-rest on a vertical bar which extends upwards sufficiently to afford a simple means of rotating the chair.

The method of examination is the following:—To examine the right labyrinth, the patient, seated in the chair, closes his eyes and sinks the chin on to the chest; the examiner stands opposite and grasps the vertical bar with the left hand, and starts rotating the chair by drawing the bar towards him. This is made clear by the following diagram.

A = the patient.
B = the examiner.
To examine A's right labyrinth the chair must be turned in the direction of the arrow.

The chair is rotated ten times (unless for any reason the patient is thought to have a very sensitive labyrinth, when only five turns are given). The head is then raised, and the patient

told to look to the right. At the same time nystagmus is examined for, and its duration noted by means of a stop-watch.

The direction of the nystagmus will be towards the right and rotatory in character; in the diagram of the eye the arrow represents the direction of the movements of the eyeball. From this, too, it is clear that the conjunctival vessels will jerk upwards.

The left side is now examined by turning the chair in the opposite direction, and the duration of the nystagmus again noted. The average duration of nystagmus in normal individuals after ten turns is about forty seconds.

It is interesting to notice that by this method each labyrinth can be tested separately, the influence on the opposite side being almost nil. This statement is borne out by examining patients in whom one labyrinth has been destroyed by operation; in these cases it is found that after turning to test the sound side, nystagmus is present in normal degree, while turning to test the operated side produces absolutely no nystagmus.

It might be thought that in this method was to be found a simple means of exactly comparing the two labyrinths, since the duration of the nystagmus is measured by the stop-watch; this is not so. In the first place the moment when nystagmus ceases is very difficult to decide, and again, many quite normal people show small differences in the duration of nystagmus from the two sides. In consequence, the discovery of differences of ten seconds in the times must not be looked upon as indicating abnormality, and only when the difference is twenty seconds or more is judgment to be passed.

4. *Caloric nystagmus.*—It has been found that if the ears are syringed with water at a temperature either considerably higher or lower than that of the body, the patient experiences vertigo, and nystagmus is produced. The probable reason for this reaction is to be found in the study of the semicircular canals. The external and superior canals reach outward almost as far as the inner wall of the tympanum, so that the water alters the temperature of the fluid in those parts of the canals nearest the tympanum, and this change of temperature causes currents in the endolymph, thus stimulating the endings of the vestibular nerve. This test is carried out as follows: Water having a temperature of about 70° F. is syringed into the ear, generally by means of a Hartmann's canula, until the patient begins to experience vertigo, or until nystagmus is noticed; the syringing is at once stopped. It will then be seen that the nystagmus, which is in a direction away from the syringed side, becomes more pronounced for a short time, and continues for some time after the syringing is stopped.

If the vertigo produced is very severe, or if the test is being used only to determine whether the labyrinth is irritable or not, warm water can be syringed in as soon as the cold water has produced its effect, and the vertigo then ceases.

On an average it is found that nystagmus begins after thirty seconds syringing, and continues for about three minutes or a little less; but variations from this average are great. In nervous persons nystagmus may occur almost as soon as the syringing is begun. When this caloric nystagmus is used to confirm the evidence obtained from the rotation, it is only necessary to observe which side is affected more quickly and more severely. Usually, when one labyrinth is definitely affected, the difference between the two sides is obvious without exact timing. When, however, this method is being used to decide on the exact relative irritabilities of the two labyrinths, the times taken to produce the nystagmus (after the beginning of the syringing), and the duration of the nystagmus so produced must be noted, and the two sides compared. The caloric reaction, brought into prominence by Bárány, is, without doubt, of the highest value, but nevertheless it has certain objections. Since the syringing with the hot or cold water owes its influence to the effect on the labyrinth abutting on the inner wall of the tympanum, it is clear that the presence or absence of the membrana tympani will largely influence the results; again, the condition of the inner tympanic wall, whether covered with granulations or eroded by suppuration, cannot fail to have similar influence. There is yet another objection; the test is required, as a rule, for cases of chronic suppurative otitis, and often for cases where cholesteatoma is present, or where an actual fistula exists in the labyrinth capsule; under these circumstances syringing water (or even lotions) into the ear is not without danger to the patient in the form of subsequent complication.

5. *Galvanic nystagmus.*—If a galvanic current be passed through a patient from one hand to the corresponding ear, vertigo is experienced and nystagmus can be noticed. When the amount

of current required to produce this nystagmus is measured, it is found to be the same, within certain small limits, in all cases.

The method is carried out in the following way: the patient holds the kathode of a galvanic current in his hand, and the anode is held against the cheek immediately in front of the ear; in the circuit is a resistance and an ampère meter. The resistance is arranged so that it can be very slowly diminished and the number of milli-ampères passing through the circuit is indicated on the scale of the ampère meter. The current is increased from nil, very slowly, till nystagmus is produced, and the number of milli-ampères read off on the scale; the current is then slowly diminished again to nil. The opposite ear is tested in a similar manner, and the number of milli-ampères compared with that previously required.

The movements of the eyeball are slower and less frequent under this test than under the caloric test, and are not so easy to observe accurately. Normally, with the anode in front of the ear, nystagmus is produced by four to six milli-ampères, but this number can be as much as ten, or even more, without abnormality in the labyrinth. Though this test is of much scientific interest, it is not of great practical value; the apparatus required is complicated, and the observations difficult to make, and, further, many patients find the effects most unpleasant; for these reasons galvanic nystagmus has not very much to recommend it.

These, then, are the three recognised means whereby the function of the vestibular apparatus can be examined. A combination of all will give quite definite information even with regard to slight affection of the labyrinth, while in the vast majority of cases one method alone will be sufficient to decide whether irritability of the labyrinth is present or not—a question of far greater importance than that of the quantitative estimation of this irritability. To decide, then, which of these methods should be used is a matter of some difficulty, certainly either the "rotation" or "caloric"; and perhaps of these the caloric is the better, as it is very simple to carry out, and the unpleasant effects produced by the cold water can be neutralised by warm water, as has already been said.

A note of warning must be added. In severe cases of vertigo where diagnosis of labyrinthitis is fairly obvious, all methods should, if possible, be avoided and the case judged from other evidence, because the reaction of such a patient to labyrinthine stimuli is extremely severe and may lead to vomiting or fainting.

In conclusion, it must be pointed out that, though the functional examinations of the vestibular and auditory apparatus have been discussed separately, no real separation can exist. The anatomical relations between the various parts of the inner ear are so close that it is difficult, if not impossible, for one part to be affected without the other. Pathological processes arising in the middle ear and spreading to the inner ear cannot fail to affect both the vestibular and auditory nerves, and in consequence the discovery of defects in the cochlear function may well indicate the presence of defects in the labyrinth; and, since the cochlea is more delicate and susceptible to stimulation than the labyrinth, its complete investigation is fully as important as that of the labyrinth.

These considerations make it clear that to come to a decision on the exact condition of the internal ear is no light matter, and this paper is not intended to do more than indicate the lines along which functional examination must be pursued to attempt to arrive at definite conclusions.

Appointments.

Civil.

Braund, H., M.R.C.S., L.R.C.P. Lond., has been appointed Clinical Assistant to the Samaritan Free Hospital.

Dawson, R. B., M.R.C.S., L.R.C.P., has been appointed Certifying Surgeon under the Factory and Workshop Act for the Maiden Newton District of the County of Dorset.

Simpson, Graham S., F.R.C.S. Eng., to be Lecturer on Operative Surgery to the University of Sheffield.

Stevens, John, L.D.S. Eng., has been appointed Honorary Dental Surgeon to the Sudbury Home for Girls.

Military.

Major G. Travers Birdwood, I.M.S., on the expiration of his appointment as Principal to the Medical College at Agra, has been placed on special duty in the Central Provinces to inspect the Dufferin Hospitals.

Books Received.—Smith's Common Remedies; Bosanquet and Clogg's Stomach, Intestines and Pancreas; Robertson's Public Health; Jellett's Midwifery, 2nd edition; Savage's Harveian Oration for 1909; Spencer and Gask's Surgery; Watson Williams's Rhinology; The Optimist; Hey Groves's Synopsis of Surgery; The Hospital Service, by the Rev. C. P. Baxter; Barnard's Abdominal Surgery; Stohr's Notes on Human Trypanosomiasis; Pope's Quiz Book of Nursing; Proceedings of Imperial Malaria Conference, Simla; Binnie's Operative Surgery.

Volkmann's Contracture.

CLINICAL LECTURE BY Mr. ROWLANDS.

GENTLEMEN,—I have under my care two additional cases of Volkmann's contracture. Although Volkmann first described this serious condition in 1875, very little attention has been given to it in the surgical text books. It is avoidable if care be taken in the treatment of fractures, but, unfortunately, many men do not know of the risk of its production until it is too late. Therefore, I venture to bring these two cases before you.

CASE 1.—The following is the report of my dresser, Mr. Milton. A little boy, T. C., aged 5, was admitted into Guy's Hospital for deformity of the right hand and fingers, due to tight splinting in the treatment of a fracture of the lower end of the humerus. The following history was given :—

In August last the patient fell on to his right arm and broke it. This was treated for five weeks in a splint. On the removal of the latter the elbow was in a flexed position and immovable, and the fingers were flexed and claw-like. As a result of massage and exercises, the patient can now extend his elbow about forty-five degrees, but his fingers are flexed when his arm is in this position. The patient complains greatly of the cold in his right hand. He burnt the knuckles of the inter-phalangeal joints of his right hand three weeks ago. When admitted into the Hospital the patient could not extend his elbow further than forty degrees. When his arm is in this position his fingers are tightly clenched, but they are extended when his hand is fully flexed at the wrist. The skin of the hand and fingers is shiny and cold. There are some scabs on the dorsal aspect of the right inter-phalangeal joints, the result of the burn. The wrist is slightly flexed. The patient is able to adduct and abduct his fingers. There is cutaneous anæsthesia below the wrist on the ulnar side of the index finger, both on the palmar and dorsal aspects. There is no loss of sensation on the radial side of the index finger. There are several splint sores on the anterior aspect of the forearm. The patient is frightened, and resents any attempt at manipulation of his crippled hand, which, he says, is very painful.

Treatment.—On the 6th December the patient was taken to the theatre and anæsthetised by the open method at first with A.C.E., followed by ether. A tourniquet was placed around the upper arm just below the shoulder joint, and an incision two inches in length was made over the outer side of the radius, and the bone was exposed by separating the supinator longus and the radial nerve from the extensor carpri radialis longior. The periosteum was incised and stripped off by means of an elevator, and about one inch of the bone removed with sharp and strong cutting forceps. A piece of the ulna was then removed in the same way, but higher up the forearm. The periosteum was then sutured by means of catgut in such a way that the cut surfaces of each bone were brought into contact, and the wounds were closed with salmon gut. These were then dressed with cyanide gauze and wool firmly bandaged before the tourniquet was removed. The fingers were then forcibly extended so as to break down adhesions. A splint was applied on the dorsal aspect of the forearm, the hands and extended fingers, and the patient was removed to bed. Ten days afterwards the stitches were removed, the wounds having healed. A splint was supplied with appliances for over extension of the elbow-joint, wrist-joint, and each finger separately. The great difficulty met with is the almost complete anæsthesia that persists in the fingers and hand. This gradually diminished, and by January 17th a very striking change had taken place in the skin of the fingers and hand, the blueness and coldness having almost gone, and the sores on the fingers having entirely healed. The fingers and thumb are still somewhat flexed when the wrist is straight. Active and passive movements, massage, and a posterior night splint are to be sedulously used in the after-treatment.

CASE 2.—A. D., a boy aged 11, fell and broke the right radius and ulna at the middle of the forearm, on July 15th, 1909.

Within a few hours he was treated by anterior and posterior fore-arm splints. These were fairly comfortable for twenty-four hours when they were taken off and re-applied. He suffered a good deal of pain during the evening and all night. On the morning of the third day the splint was removed and blisters were found on the dorsal and ventral surfaces of the forearm, in the lower third. The hand was greatly swollen and congested, and the fingers were clenched. A long external splint was applied. An attempt was made to correct the deformity of the fingers by massage and movements which were continued without any appreciable benefit for two and a half months when the patient first came to see me. The degree of contracture is well shown in Fig. 1. The range of movement was very limited and the muscular power was very poor. The fingers were blue,

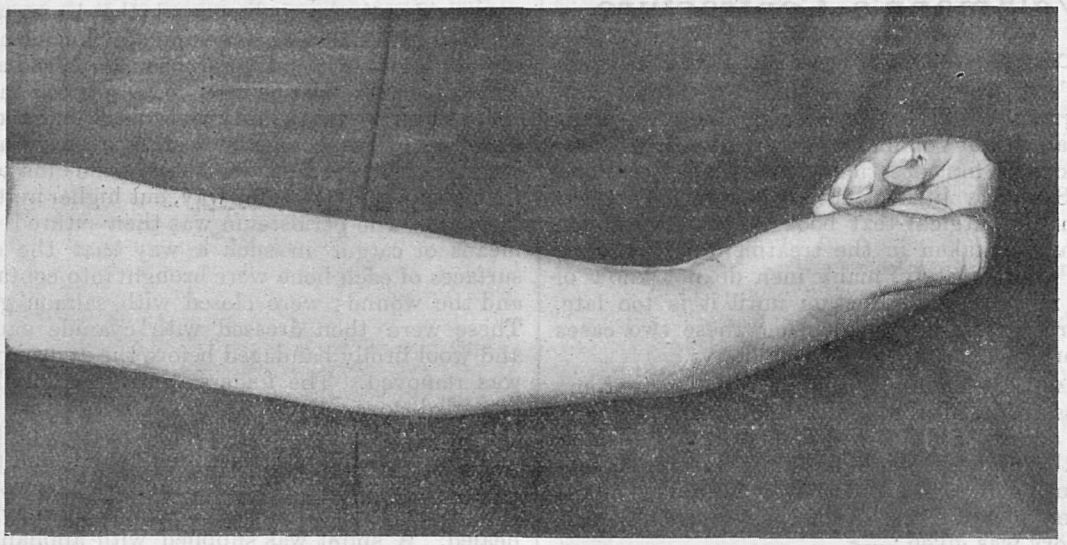

Fig. 1.—D. Before treatment by special splint. Note the clenched fingers and a trophic sore on the forefinger.

cold and shiny, and their sensation was greatly impaired. The fingers could be completly extended when the wrist was fully flexed. It was therefore decided to try a modification of Mr. Robert Jones's method of treatment. The metal splint shown in Fig. 2 was flexed at the wrist and applied to the fingers, hand, and forearm. By gradually straightening the splint a good deal of traction was made upon the contracted muscles. The splint was removed and left off for about an hour every morning and evening. During this time active and passive movements were carried out. The boy was encouraged to use the hand as much as possible. The deformity has gradually diminished, and the range of movement and the strength of the muscles have gradually improved. The improvement is progressing, so that it is unlikely that any operation will be necessary.

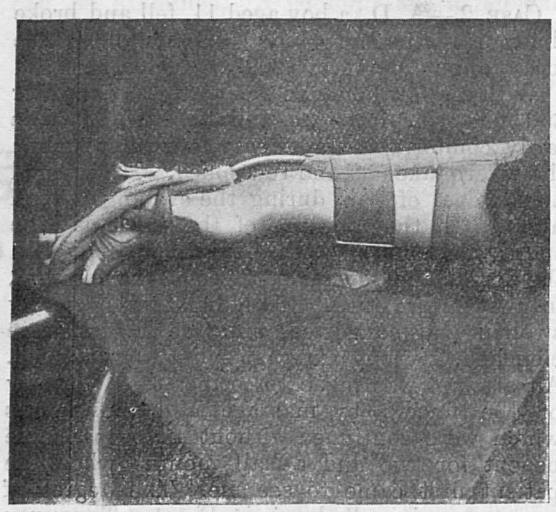

Fig. 2.—D. With the splint on after six weeks of treatment with it.

Mr. Dudgeon,[1] in an excellent paper, gives the following definition :—

Definition.—"A contraction of the fingers, and sometimes of the wrist, which comes on rapidly with loss of power, which is not absolute, in the forearm muscles after a severe injury, usually in the region of the elbow-joint, generally in young children. The deformity is due to changes in the flexor muscle without injury to the peripheral nerves, caused, in many cases, by tight bandaging and the pressure of splints."

Etiology.—In nearly all recorded cases tight splinting is the cause. In a few exceptional cases injury or compression of the main artery of the limb has been given as the cause, but even in some of these a splint has also been applied. The most common fractures that it has complicated are, (1) separation of the lower epiphysis of the humerus and fracture of the bones of the forearm. It seems to be peculiarly liable to follow the use of the anterior angular

[1] *The Lancet*, Vol. 2, 1905, p. 1169.

splint, which, by its extreme compression, has also led to gangrene of the forearm. It may follow the use of any splint. The splint may not appear to be tight when it is applied, but as the limb swells during the first day or two after the injury, the compression may gradually increase, until at last the muscles become devoid of blood. It is particularly important to remember that although there may be a great deal of pain in the early stages, the compression at last produces

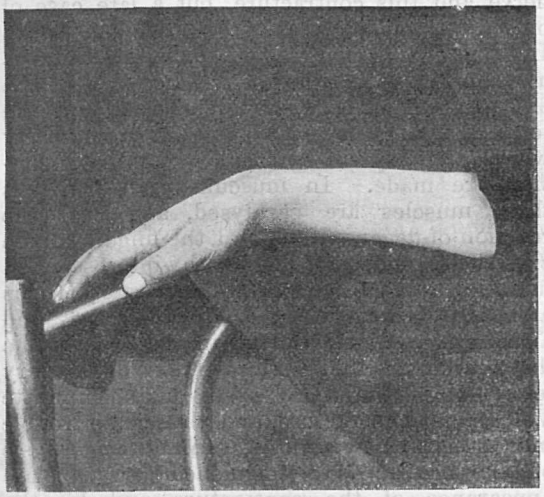

Fig. 3.—D. Side view of hand after treatment for six weeks. Notice the improvement. This is progressive.

anæsthesia. This may deceive the parents in spite of the unusual swelling and congestion of the hand. The result is that the tight splint is not removed before irretrievable damage is done.

The following remarks upon pathology, diagnosis, and prophylaxis are taken from my paper in *The Lancet*.[2]

Pathology.—The surgeons who have examined the contracted muscles all agree that they are pale, firm, and fibroid, but how the healthy muscles have arrived at this state is uncertain. It is not likely that their fibroid condition is secondary to any lesions of the median and ulnar nerve trunks, which give twigs to supply the muscles involved, because paralysis does not precede contracture, as it always does in nerve disease. Moreover, there is rarely any change in the electrical reactions[3] of these nerves or any reaction of degeneration in the contracted muscles which remain capable of producing voluntary movements if only their tendons be relatively or actually lengthened, so as to allow a range of movement. There is no paralysis of the small muscles of the hand, which are supplied by these two nerves, and anæsthesia of the fingers is rarely complete, and is only an occasional complication. It is not denied that injuries of these nerves may co-exist with Volkmann's contracture, and sometimes the nerves have been found imbedded in scar tissue, but otherwise healthy in appearance.

The fibrosis is probably the result of a myositis, which is usually acute, but may be subacute in some cases. No reaction of degeneration occurs in this condition. This myositis may have been induced by several causes, of which malnutrition from a prolonged anæmia is the main factor, and direct injury of the muscles by splint pressure is another important one. Volkmann believed that the compressed muscle fibres died and entered into rigor mortis. It is probable that some of them may do this, and it may account for the early onset of the contracture, which sometimes comes on within a few hours of the application of the splint and too early for inflammation to be its cause; but this early onset may be due to mere spasm. All the fibres certainly do not enter into rigor mortis, for this is incompatible with the partial recovery which we now know to be possible. The fibres directly compressed between the splint and the radius or ulna would be the most likely to die, but many must escape into com-

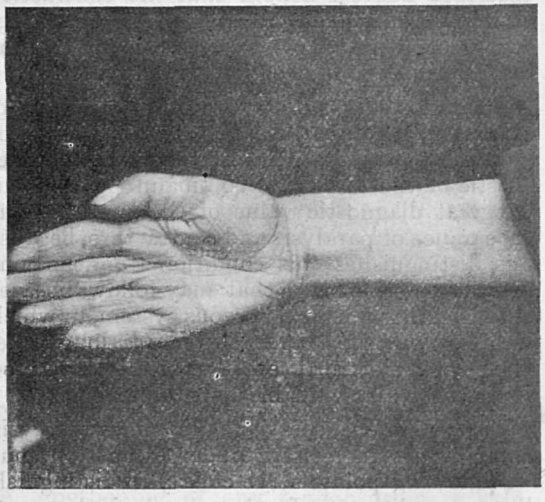

Fig. 4.—D. Front view of hand after treatment for six weeks.

[2] *The Lancet*. Vol. 2, 1905, p. 1169.

[3] Oppenheim: Text-book on Nervous Diseases, 1900.

parative safety at the sides of the bones or into the interosseous space. From their anatomical relationships none of the muscles could have all their fibres directly compressed, and hence it may be that none are beyond the hope of recovery.

It is very probable that the connective tissues, lymphatics, vessels, and small nerves between the muscle fibres are also damaged by the anæmia and pressure. When the splint is removed and the blood is allowed to enter the damaged vessels again, all the phenomena of inflammation proceed apace, and the inflammatory products soon surround the muscle fibres, many of which, no doubt, undergo the vitreous and granular changes characteristic of myositis, and became absorbed and lost for ever. Hence the extreme rarity of a complete and perfect recovery either in the function or size of the damaged muscles. Any attempt to stretch the affected muscles causes great pain in the early days of Volkmann's contracture, owing to their inflamed condition probably.

A similar deformity may sometimes arise as a result of cellulitis of the forearm, as in Anderson's[4] case, which followed an adder bite. Talipes equinus may be due to suppuration or cellulitis of the calf muscles; it is not at all probable, however, that Volkmann's contracture is ever chiefly due to cellulitis spreading from the sore which is so commonly found, for the disease develops when no sores are present or are only to be seen in the dorsal surface of the forearm. It is noteworthy that in these cases no contraction of the extensors ever develops. In my case described above I believe that the contraction of granulation tissue in and around the large deep ventral wound contributed towards making the deformity so unusually severe.

Diagnosis.—It is not easy to mistake a case of Volkmann's contracture for anything else, for the history and the deformity are both characteristic of the disease. Volkmann pointed out the great diagnostic value of the simultaneous appearance of paralysis and contracture, because this distinguishes this condition from the contractures of the hand that may follow diseases of the nerves or central nervous system, in which paralysis precedes contracture by a long time. The normal electrical reactions of the contracted muscles are also valuable aids in diagnosis.

The "main en griffe" of late ulnar paralysis simulates the deformity under discussion, but the following points serve clearly to distinguish the two conditions. In ulnar paralysis there are loss of use, wasting and reaction of degeneration in all the small muscles of the hand except those forming the thenar eminence, and the two outer lumbricales, and the lean look of the metacarpals due to wasting of the interossei is very striking. The wrist is not flexed, and there may be anæsthesia or paræsthesia of the little and half of the ring fingers, and some trophic inner changes, such as glossy skin, eczematous rash, and cyanosis of the same fingers. There is no resemblance between paralysis of the median nerve and this contracture, but a late case of musculo-spiral palsy may be mistaken for it. In Volkmann's contracture, however, there is no paralysis or reaction of degeneration of the extensors of the fingers and wrist, and the tendons of these muscles stand out prominently when voluntary but fruitless attempts at extension are made. In musculo-spiral paralysis these muscles are paralysed, and give the reaction of degeneration, and the fingers can be extended by means of the healthy interossei and lumbricales. Moreover, the supinator longus and the triceps may also be affected, and anæsthesia may be observed in the area of the distribution of the radial nerve. Temporary lesions of the peripheral nerves may complicate Volkmann's contracture, and thus some trouble may arise in the diagnosis. Infantile paralysis of the forearm is distinguished by the late appearance of the contracture and by the presence of reaction of degeneration.

In cases of infantile cerebral monoplegia the deformity is usually very different; there is no clawing of the hand and the elbow is flexed, and the absence of any history of splinting generally settles the diagnosis; but I have now a case under observation in which the deformity very closely simulates that of Volkmann's contracture, but the flexion of the fingers can be corrected by manipulation, the contracted muscles relaxing their spasm after a few minutes. The hand in this case is in a prone position, and supination to the full degree cannot be obtained by any means. No splint had been ever employed in this case.

It is difficult to imagine anyone mistaking a case of Volkmann's contracture for functional disease, but this mistake has been made; the absence of any relaxation of the fibroid muscles under an anæsthetic would at once prove the contraction to be due to a more permanent cause than hysterical spasm.

It should be remembered that contracture does not invariably occur in ischæmic paralysis, for a continuous and prolonged use of an

[4] Anderson: The Deformities of the Fingers and Toes, p. 66.

anterior splint may prevent any contraction of the inflamed muscles.[5]

Prophylaxis.—I believe that a proper appreciation of its true cause should render Volkmann's contracture far more rare than it now is. Tight splinting is the one great cause, and is clearly avoidable; there can be no advantage in applying a tight splint, especially soon after a fracture has been sustained, and some allowance should always be made for swelling from hæmorrhage and inflammation. Above all, the child should be seen and the limb carefully examined at least once daily for the next few days, and it should be remembered that no pain has been complained of by most of the subjects of ischæmic paralysis; the nerves are probably anæsthetic from severe compression. The splints should be frequently readjusted. It is noteworthy that an anterior splint is more dangerous than a posterior one, and that an anterior angular is very dangerous, and an external angular splint is much safer than an internal angular. A plaster splint that completely encircles the limb, or one that exerts pressure on the front of the forearm, should be avoided.

Treatment.—This may be divided into:—

a. Conservative.

b. Operative.

Conservative.—Slight degrees of the deformity seen early are amenable to treatment by massage and movements, both active and passive. These have to be started early, and carried out thoroughly for a long time. Passive movements under an anæsthetic, as suggested by Volkmann, are useless, for an anæsthetic does not relax the diseased muscles. When the contracture is so severe as to allow little or no passive movements, this conservative treatment is of very little value. It may be supplemented by apparatus. Mr. Robert Jones[6] has lately devised a simple method of dealing with minor degrees of the deformity by means of apparatus.

He flexes the wrist to the full, thus allowing the fingers to become extended, and he then fixes a splint of zinc or sheet iron to the dorsal aspect of each finger to maintain the extension. The metacarpo-phalangeal joints, which are then flexed, are gradually and frequently extended, both passively and actively, until after a few days the posterior splint can be applied from the wrist to the tips of the fingers to maintain the extension of the fingers and the metacarpo-phalangeal joints. To allow this the wrist becomes flexed. Active and passive extension of the wrist are now performed regularly and persistently. Then a splint, extending from the elbow to the tips of the fingers, is applied, and its shape "is at intervals altered so that by degrees the wrist is fully extended. For some weeks this position is maintained until all contractile elasticity is lost. The splints are then removed and the hand massaged." I have found a modification of this method to be very efficient in one of my patients, but it is only likely to be completely successful in mild cases.

Operative.—For severe contracture without range of movement, operations have to be undertaken. Some years ago, when the pathology of the disease was not fully understood, surgeons used to expose the various large nerve trunks with the idea of releasing the supposed pressure upon them of contracting fibrous tissue. It is needless to say that these operations did not do any good. At the present time there are two main operative procedures—

1. Tendon lengthening.

2. Excision of portions of the radius and ulna.

1. *Tendon lengthening.*—It must be remembered that the deformity is practically limited to little children, and that the difficulties of tendon lengthening in them are very considerable. All the superficial and deep flexors of the fingers and thumb need lengthening and the two flexors of the wrist. It may also be remembered that the tendons of the deep flexors of the fingers are not very distinct at the wrist. Moreover, lengthening of these tendons does not correct the pronation of the forearm, so that the pronator quadratus, and the pronator radii-teres, have to be divided or lengthened. In all about thirteen shortened muscles require attention. Although good results have been published, notably by Mr. Littlewood[7] and Mr. Page[8], it is a difficult operation, and it is not surprising that some of the tendons which have been slit have not joined well. In one patient the flexor sublimis of the index finger failed to unite, and it is even possible that the wrong tendons may be joined together. Moreover, as all the tendons have to be dealt with at the wrist, it is not surprising that the tendons are apt to get adherent to one another in spite of the use of protective membrane, and care taken in the after-treatment by massage and movement. Further, the lengthening of any tendon is, as a rule, followed by some wasting and weakness of the

[5] Turney, quoted by Dudgeon.

[6] The American Journal of Orthopædic Surgery, April, 1908, p. 6.

[7] *The Lancet*, February 3rd, 1900, p. 290.

[8] *The Lancet*, January 13th, 1900, p. 83.

muscle, and as these muscles are already weak and contracted, it is hardly good surgery to run the risk of reducing their value.

2. *Excision of portions of the radius and ulna.*—This method, which was originated I believe by Mr. Raymond Johnson,[9] is an easier and much better method. I published a very successful[10] case with photographs in *The Lancet*, and there drew attention to the advantages of this operation.

"1. The operation is easier and takes much less time than tendon lengthening.

2. The radius can be drilled and sutured in such a manner as to correct the crippling limitation of supination of the hand, which is practically always present.

3. There is no interference with tendons, and therefore no risk of non-union or weakness of any of these tendons.

4. If any contracture of the flexors of the wrist be present, as in Mr. Davies-Colley's[11] case, this is also corrected at the same time by this single operation.

5. No nerves are liable to injury during the operation."

The chief objection to this operation is that the bones may fail to join. In one of these recorded cases the union was delayed for some months after the operation, and the boy was compelled to wear a support for the forearm. In my first patient[12] an X-ray photograph showed the wire to have become loose and to be lying amongst the muscles of the forearm about a year after the operation, but it seemed to do very little, if any, harm. Wiring or plating is not really necessary, as shown by one of the patients at this lecture. Here I only shortened the periosteum around the gap. This has the advantage of leaving no unabsorbable body which may lead to a certain amount of weakness from absorption at the site of the metal support. It also allows the lower part of the radius to be rotated outwards upon the upper part so that the limb can be put up in the semi-supinated position during healing. The shortening of the forearm is not a matter of serious consequence and is hardly noticeable. It is important to remove enough bone. As a rule it is necessary to take out about one inch of the radius and ulna. This should be done at different levels in the two bones in order to prevent any possibility of cross union or limitation of rotation from narrowing of the interval between the bones. Occasionally one or two tendons of the flexor sublimis digitorum may need lengthening after bone resection.

Prognosis.—Until recent years this condition was regarded as practically hopeless. In untreated cases the disability became worse year by year, and I have recently seen a patient who had been inefficiently treated fourteen years ago. I had also seen him at that time. In the interval his forearm had withered more and more, and his hand had become more contracted and useless, so that the only treatment that I could suggest was amputation at the elbow joint. Under modern treatment the prognosis is very much better, but it stands to reason that the dead muscle fibres will never come to life again, and that new ones will not form to replace them. It is only to be expected, therefore, that the forearm will remain weak, and that the range of movement will be somewhat restricted. The amount of movement and hypertrophy depends a great deal upon the care and devotion given to the after-treatment. Massage, electricity, passive movements, and, above all, voluntary movements, are most useful after the operation, and they should be continued for at least a year.

[9] *The Lancet*, March 12th, 1898, p. 722.
[10] *Loc. supra cit.*
[11] Guy's Hospital Gazette, October 5th, 1898.
[12] *Loc. supra cit.*

Notice.

Royal Naval Medical Service.

The next Examination of Candidates for Commissions in the Royal Naval Medical Service will be held at Examination Hall, Thames Embankment, on the 2nd and following days of May, 1910. The number of Commissions to be granted will be fifteen. The Regulations for Entry and the form to be filled up by Candidates will be supplied on application to the Medical Director-General, Admiralty, 18, Victoria Street, London, S.W.

Candidates must not be under 21 nor over 28 years of age on the day of the commencement of the Competitive Examination, and must be registered under the Medical Act in force as qualified to practise Medicine and Surgery in Great Britain and Ireland.

The Examination will consist of:—*a.* Medicine, including Medical Pathology and Therapeutics; *b.* Surgery, including Surgical Pathology and Clinical Surgery.

Marks will be allotted as follows:—Medicine: Paper, 400; Clinical, 400; Oral, 400; Total, 1,200. Surgery: Paper, 400; Clinical, 400; Oral, 400; Total, 1,200.

By order, J. PORTER,
Admiralty, February, 1910. Director-General.

A Surgical Text-Book.*

The value of a text-book of surgery depends very largely upon the excellence or otherwise of the sections dealing with general surgery and surgical pathology, and with the subjects so essential to the general surgeon as injuries of all kinds, as diseases of the blood-vessels, bones, and joints, and as hernia. In the special surgery of the various organs or parts, a general text-book is of little value; these branches of our subject can only be learnt in the wards and Out-patients, and any student wanting to read them would probably gain more by doing so in monographs or isolated papers. By this we do not mean that the parts of surgery mentioned above can be learnt in any other way than by practice. This, indeed, is so old an observation that we should apologise for laying stress upon it were it not so frequently forgotten by students. A good text-book is most necessary to give the student a start from which he can begin making his observations, and to guide these observations when he has begun.

Judged by the above criteria, we can recommend the tenth edition of Walsham's Surgery, which now bears the names of Spencer and Gask.

The first 150 pages are devoted to general surgical pathology, followed by 50 pages on general surgery. Both these sections are good, the pages on inflammation being an excellent brief description of a subject that the student always finds difficult to read, and the surgeon finds difficult to write in a condensed form, to judge from the majority of descriptions in the surgery books. At the end of the section on general surgery a short article on anæsthetics, general, local, and spinal has been wisely introduced; such an article cannot be made to please everyone, so varying are the tastes of surgeons in their choice of anæsthesia, but we think the omission of ether given by the open method is a grave one in an up-to-date text-book, though we are glad to see a few lines given to the use of morphia associated with anæsthetics.

The next section deals with the surgery of the vascular system, and what is there is well done; yet we think that it is a mistake not to have a paragraph on the diseases of atheroma, arterio-sclerosis, and endarteritis obliterans. It is true these are referred to under the subjects of gangrene, aneurysm, etc., and there is no actual surgical treatment directed to the improvement of the actual diseased arteries, yet these diseases are causative factors in such important surgical disorders, and they are so important in that estimation of the general condition of the patient upon which the successful carrying through of surgical treatment so largely depends that we think they should be given a separate description in any text-book of surgery, and not merely passing allusions.

After a good chapter on the surgery of the nerves and muscles we come to that on the bones and joints. We think this arrangement of putting these two subjects together is very valuable. It saves much unnecessary repetition, and brings the text-book more into line with what is seen clinically. We are glad to see the operative treatment of simple fractures is seriously discussed; we think even more space might be given to the subject. The section is illustrated by a most valuable series of radiograms by Dr. Hugh Walsham. We think it a pity the various fractures around the ankle could not have been more fully illustrated in this way rather than by means of the diagrams after Treves in fig. 219. In these the fibula is always represented as being broken absolutely transversely, whereas had radiograms been used we think it would have been apparent that this bone is always broken in a spinal rather than a transverse direction. So also we think the rare rather than the usual displacement in separation of the lower epiphysis of the femur is described and figured in fig. 207. The authors seem to think the reduction of a Pott's fracture an easy thing to do; we only wish it were as easy in practice to obtain good apposition in this injury as it appears to be from their description.

Of the parts of this book that have been specially selected for notice, we think the article on hernia is least well done, and must frankly admit that we are disappointed with Messrs. Spencer and Gask here; we do not mean that there is anything actually wrong in their description, but that they have not done justice to the importance of the subject, and should like to see the whole article more fully written and more fully illustrated. If there is justification for expansion on any one subject in a surgical text-book that subject is hernia.

A review of this book cannot be considered as complete without some notice being taken of the diagrams and illustrations. These are excellent. Of the coloured plates we shall have occasion to speak later; it is the diagrams that we particularly wish to lay stress on here, especially those on the general pathology and on inflammations of the bones and joints. The cross sections across different parts of the limbs should also be found extremely useful.

The tendency of text-books generally to enlarge and become more costly is well exemplified in this book; each edition gets larger and more expensive, and we earnestly recommend the authors to stop any further growth in these directions in future editions.

But surgery continues to grow, and we have ourselves pointed out some omissions in the course of our review, and so it may be hard to do this. We should like to suggest to the consideration of Messrs. Spencer and Gask two things; to cut out all the descriptions of operations and the coloured plates.

We doubt if any student goes in for his final examination without procuring either a small or a large work on

*_The Practice of Surgery_, with 20 coloured plates, 28 skiagram plates, and 707 black and white illustrations. By Walter George Spencer, M.B., M.S, Lond., F.R.C.S. Eng., Surgeon and Lecturer on Surgery, Westminster Hospital, etc., etc., and George Ernest Gask, F.R.C.S. Eng., Assistant Surgeon and Demonstrator of Practical Surgery, St. Bartholomew's Hospital. (London: J. & A. Churchill.) pp. 1234. 22s. net.

operative surgery; he seldom reads the operations in a general text-book, and a description of an operation is of little value unless it is in more detail than there is room for in such a treatise. With regard to the coloured plates, we feel they are a luxury, and very expensive ones at that; the only ones of any real value to the student are those on ophthalmoscopic appearances of the optic disc, and cystoscopic appearances of the bladder; the other ones are very decorative, but are not of sufficient importance to warrant the increase in cost that their inclusion must entail.

Pass List.

University of London.

The following list has been accidentally overlooked:—

FIRST M.B., DECEMBER, 1909.

P. D. Scott.	A. L. Stokes.
R. S. Stewart.	H. Q. F. Thompson.

Guy's Physiological Society.

THE Fourth Annual Dinner of the Society was held on Tuesday, March 1st, in the College Reading Room. Dr. Pembrey (President) was in the chair, and Messrs. Thompson, Hughes, Leeming, Ryffel, and Kennaway (Vice-Presidents) were present, making a total of about fifty members and visitors.

Dr. Pembrey supplied horseflesh and black bread as a surprise course. To all partaking of this he also provided smokes.

The toasts and speeches were numerous.

Mr. Leeming briefly proposed "The Society," to which the Secretary replied.

Mr. Thompson proposed "The President" in true anatomical style by throwing contempt on physiology as a whole, but mentioned that one of the chief causes of the success of the Society was that Dr. Pembrey was President. The President, in replying, rebuked Mr. Thompson for clothing his speech in a garb of obscure anatomical terms, and said that the principal use of the Society was that of teaching men to speak, and also in allowing absolute freedom of criticism.

Mr. M. Scott proposed "The Vice-Presidents," to which Messrs. Thompson, Leeming, Ryffel, and Kennaway replied.

Mr. Creasy proposed "The Secretary and Committee" at some length, dealing with each member separately. The Secretary and Messrs. Bennett, Ryle, and Roberts replied.

A toast to "His Majesty's Forces" was proposed by Mr. Ryle. Mr. Hoby replied on behalf of the Navy, and Mr. Oram, on behalf of the Army, mentioned that twenty members at least who were present were in some way connected with the Territorial Army.

Mr. H. N. Eccles proposed the pianist, Mr. Moberly, who replied.

Mr. Danby proposed Mr. Schlesinger, who contributed some topical verses to a song rendered by Mr. H. N. Eccles. Mr. Schlesinger replied.

Between the speeches songs were rendered by Messrs. Moberly, Oram, Cline, Eccles, and George. The proceedings were terminated at 11.15 p.m. with "Auld Lang Syne" and the National Anthem.

The dinner was voted a great success by all.

A MEETING of the Society was held on Monday, February 21st. Mr. Thompson was in the chair. The President and forty-seven members were present. Mr. Ryle read a very interesting paper, entitled, "Alcohol and the Organism."

The paper was divided into two main divisions: (1) The effect of alcohol on the living organisms; (2) The influences of the use of alcohol on the social organism.

(1.) He started by mentioning the fact that alcohol is a strong protoplasmic poison, and that many dilute solutions inhibit entirely or in part the growth of most of the lower organisms.

On the human subject its effects were on the whole bad. It has a strong irritant action on the mucous membrane of the stomach, by which the quantity of secretion produced is augmented. The fact that alcohol is absorbed quickly from the stomach and the irritant effect are the two causes producing stimulation. The general effect on the nervous system is, finally, one of depression. It has very little food value, although it will act as a fat sparer, and can be used, in very small quantities, as a food without pronounced evil effects. Larger doses increase the output of nitrogen in a patient who is in nitrogenous equilibrium; this demonstrated its toxic effect.

Experiments have been made which seem to prove that immunity to disease is not so easily obtained in alcohol drinkers, and that plumbism and other industrial diseases are aggravated by, if not caused by, alcohol, which is used by the men under the mistaken idea that it prevents the disease.

(2.) The effect of alcohol on the social organism could best be seen by studying the children of alcoholics. In most cases examined the progeny were markedly degenerate, as shown by malformations and nervous diseases. The infant mortality in cases where the parents were great drinkers of alcohol was much greater than where the parents were not addicted to alcohol. Its effect on the parents was also dealt with, and statistics were given to prove that deficient lactation is in great degree the result of alcohol, and that, moreover, this deficiency of lactation could be transmitted by an alcoholic father to the daughter where the mother was quite normal.

Trades in which the men were accustomed to drink a large quantity of alcohol showed a very much greater percentage of suicides than did other trades.

Two Cases from General Practice.

Rupture of the Sartorius.

C.P., age 20, had been in some training without altering his diet. While running in a 440 yards race, towards its end, where there was a slight rise in the path, he felt something snap about the anterior superior spine of left ilium. By effort, though in pain, he ran on into goal, and eventually with limping, by train and tram, he got back to the city and went to bed.

On examination there was some swelling, and ecchymosis in a circle round the left anterior superior spine; tenderness on touch here, and pain when moving the leg. He could not flex the knee-joint, nor raise his thigh. To cross the room he crawled on the floor, dragging his left leg extended. Some capsicum and soap liniment was used locally while he was kept in bed, and some strychnia mixture given. He steadily improved, so that within a week he could flex his leg on his thigh half-way, but had to complete the flexion by pulling his leg with his hand. In a few days more he could walk with an extended leg, and in seventeen days was at work in the warehouse again. A month after the accident he joined his yeomanry regiment for their summer camp.

This accident seems to be quite uncommon, as it is hardly named in surgical literature. In vol. i., p. 993, of Holmes and Hulke's "System of Surgery" mention is made of a pathological specimen in a man, age 40, showing a complete rupture in middle-third of sartorius, united by fibrous bands.

In *The Lancet*, November 8th, 1873, p. 662, at the Royal Free Hospital, while a man was sitting squatting, another man fell across his bent knees. The squatter felt no pain till trying to rise to his feet. The sartorius was dislocated backwards by rupture of its anterior fasciculated expansion. There was swelling, and the dislocation was reduced by flexing the leg. The man was kept for fourteen days with a pad over the place and with a long splint. After this the leg was put into plaster of Paris, and he left the hospital in six weeks.

Overdose of Sulphonal.

A MAN, age 34 (with wife and children), engaged in insurance canvassing, complained of brain fag and overwork. He took fifteen five-grain tablets of sulphonal, and it is suspected that he had taken narcotics on previous occasions. He was seen *ten days* after he had taken the seventy-five grains. He could not keep awake if left alone, and he could not walk straight alone. He said he wished to commit suicide. His pupils were equal and of medium size.

At the end of *seventeen days* he was still sleepy and stupid, though he had been nursed and medically cared for with administration of strychnia at a London hospital.

It was *three weeks* before he was safe to be left alone. He had ceased to talk of suicide, and seemed anxious to return to his home by train. The lengthy symptoms seemed to point to an accumulation of the drug in the system.

"AFTER THIRTY YEARS."

The Physical Society.

A Pathological meeting was held on March 3rd, Mr. A. H. Crook in the chair. The following specimens were shown:—

(*a*) Sarcoma of antrum,
(*b*) Twisted ovarian cyst ... ... Mr. James.
Osteo-chondro-sarcoma ... ... Mr. Bodkin.
Sarcoma of lung ... ... Mr. Allen.
Fibroid simulating sarcoma ... Mr. Chaning Pearce.
Hæmorrhage into the suprarenal capsule in whooping-cough ... . Mr. Mullally.
Sac of a strangulated inguinal hernia, showing a band Mr. James.
(*a*) Infective endocarditis,
(*b*) Sub-acute atrophy of liver, with regeneration, Mr. Greenwood.
Polypus of large intestine with diverticulitis, Mr. Bodkin.
Large loose body from knee-joint ... Mr. Warner.
Abscess in kidney ... ... Mr. Crawford.
Tuberculous kidney ... ... Mr. Crook.
Achondroplasic fœtus ... ...Dr. Rippmann.

About forty members were present, a number of whom took part in the discussions on the specimens.

Dental News.

ANALYSIS OF DENTAL PRACTICE FOR THE YEAR 1909.

Gold fillings	2,610
Plastic fillings	7,162
Crowns	547
Regulation cases	81
Dentures	96
Scalings	619
Devitalised teeth	2,543
Temporary Dressings	3,200
Extractions under anæsthetics ...	5,292
Patients—	
Extractions without anæsthetics ...	5,710
New patients in conservation room ...	5,498
Attendances in conservation room ...	20,407

Papers by Guy's Men.

A. F. A. Howe, L.D.S. Eng. Dentistry in the Navy.—*British Dental Journal*, 15th February, 1910.

W. Arbuthnot Lane, M.S. Lond., F.R.C.S. Eng. A Singular Combination of Fractures of the Leg. (*Illustrated.*)—*Lancet*, 26th February, 1910.

Pavy Gymnasium.

On Thursday and Friday, the 24th and 25th February, a series of competitions was held in the Pavy Gymnasium, in place of the Assault-at-Arms which has for some years been a feature of the Gymnastic Club's programme.

Boxing and gymnastics attracted a fair number of entries and provided sport of a high class, and though no fencing was included owing to lack of competitors, the introduction of wrestling was an interesting novelty which, perhaps, more than compensated for the absence of the swordsmen. We understand that a flourishing wrestling club exists at one of the other large hospitals, so that the time may not be far distant when wrestling will become a part of the programme at the Inter-hospital competitions. In view of this fact, it was satisfactory to note that a good number of men came forward to compete, especially in the light-weight class, and if the form displayed was not more brilliant than could be expected of men who were making their very first attempt, at all events great promise was shown by several competitors, and every bout on the programme was well contested. It is hoped that the Clubs' Union may be able to see its way to provide a wrestling mat for the Pavy Gymnasium, for there is no doubt that a great deal of interest has been aroused by these competitions, and a large number of men would be found glad to avail themselves of the opportunity of taking part in this fine sport.

THURSDAY.

On the first evening the programme was as follows:—

Boxing.—Light-weights. 1st Round: Rhys Evans beat Minns. 2nd Round: Hancock beat Bacon. H. C. Godding beat Rhys Evans.

Middle-weights. G. D. Eccles beat E. A. Leviseur.

Feather-weight. Final Round: King v. York-Moore. These two made a very closely-matched pair, the evenness of the contest being maintained from start to finish. The pace was extremely fast throughout, and the hitting clean. The judges disagreeing, the referee gave King the decision. The boxing was of a high class, and made us very hopeful of our chances in the Inter-hospital Competitions. King showed no falling off from his form of previous years, and York-Moore made an admirable first appearance.

Wrestling.—Middle-weights: Barrow-Clough beat Partridge in 1 minute 50 seconds; Oram beat H. J. Leviseur in 2 minutes.

An exhibition bout in the catch-as-catch-can style was given next by P.C.'s Dear and McNeillie of the City of London Police.

Light-weights.—1st Round. Passey v. Stephens. The last named put up a fine resistance against a stronger and heavier opponent, and was not pinned until 6 minutes 40 seconds had elapsed.

Joly v. Ruck. This pair greatly delighted the audience by their quaint antics, and intentionally, or otherwise, provided the comic relief of the evening's entertainment. Joly, if somewhat the weaker as a low comedian, proved the superior wrestler and won the bout.

Camp v. Samuels. Both showed a fair knowledge of the game, and an interesting bout ended in a victory for Camp.

Barrow-Clough v. Purkis. This bout ended in a fairly easy victory for Barrow-Clough, though the opening suggested that Purkis would prove a hard opponent to throw.

Heavy-weights. Watkin v. Danby. A very strenuous and hotly-contested bout. Danby succeeded in throwing his opponent, but was not quick enough to pin him, and Watkin, who had the advantage in weight, eventually succeeded in gaining a fall in 6 minutes 30 seconds.

FRIDAY.

Wrestling.—Light-weights. Semi-final. Barrow-Clough beat Passey in a short but strenuous bout. Camp beat Joly after a spirited contest lasting between two and three minutes.

Heavy-weights. Final. Watkin v. Oram. There was a great disparity in weight between the two combatants, but Oram, the lighter man, appeared to have a superior knowledge of the game. After the first three or four minutes Oram did most of the attacking, but Watkin showed a sound knowledge of defence. After more than nine minutes of strenuous wrestling, Oram worked his opponent into a hopeless position, and Watkin was saved from a fall by the call of time. The bout having reached the time limit of ten minutes, Oram gained the fall on points. On resuming, Watkin jumped in and rushed his opponent to the ropes, where a misunderstanding clearly took place, and Oram, who appeared to make no resistance to his opponent's hold, was very heavily thrown in sixteen seconds. The third bout was well contested, but after three minutes' wrestling Oram was clearly tiring, and Watkin, making good use of his weight, gained the fall in 3 mins. 32 secs. and won the match.

An exhibition bout followed between P.C. Sewell and P.C. Shepherd, both of the City Police. This was in the Cumberland and Westmorland style, in which Sewell holds the championship.

Light-weights. Final. Barrow-Clough v. Camp. The combatants in this bout also were very well matched, Barrow-Clough having the advantage in weight, while Camp appeared somewhat cleverer and quicker. In the first bout, after vigorous attack by each in turn, Barrow-Clough placed Camp on his shoulders in 5 mins. 15 secs. After the interval both went all out, though Camp did most of the attacking, and gave his opponent some anxious moments by means of a hammer lock which he succeeded in fixing. Barrow-Clough, however, succeeded in escaping from this hold, but was thrown after an exhausting tussle in 7 mins. 35 secs. The deciding bout was of a very even character, but the advantage lay on the whole with Barrow-Clough, and when at the end of ten minutes no fall had been scored,

he was returned the winner on points, and so won the match.

Heavy Weight. Wills v. Pern. Wills had a slight advantage in weight, but there was nothing between the two in the matter of inches. Wills boxed with great determination, and on several occasions used both hands with considerable success. Pern, however, was well served by a beautiful straight left, and using this in the last round with considerable effect, he had Wills rather weak towards the finish. The judges disagreed, and the referee awarded a very close bout to Pern.

Middle Weight. Final. G. D. Eccles v. Millett. Millett was quick but rather erratic, and at no time showed very great confidence. The bout, however, was very close up to the last round, when Eccles forced the attack, and scoring well with his left, gained the verdict on points.

Godding being unable to turn out in the final of the light weights, owing to an injured thumb, Hancock, the winner, boxed three fine rounds with J. Shine, the club's popular instructor.

The final of the middle-weight wrestling competition should have been contested next, but, on the very sportsmanlike suggestion of Barrow-Clough, was postponed, since Oram, the other finalist, was quite unfit to wrestle after his bout in the heavy-weights.

Gymnastics produced a very close competition between Bowes and Barrow-Clough, with Sutton only a little way behind the pair. The judges awarded the prize to Bowes, who thus will, with Barrow-Clough, represent the hospital in the Inter-Hospital Competitions.

Mr. Lane, who was present throughout the evening, then presented the prizes, and the entertainment was brought to a conclusion with a hearty vote of thanks to Mr. Lane for presiding, and to the following gentlemen for assisting in various capacities:—

Mr. Higgens, Dr. Allport, Dr. Minett, and Mr. J. G. Ross, boxing judges; Mr. R. P. Watson, Mr. Seaton, of the City Police, and Messrs. Ellman and Clark, of the London Amateur Wrestling Society, judges of wrestling, and other members of the City Police for giving wrestling exhibitions.

Papers by Guy's Men.

A. Ernest Maylard, M.B., B.S. Lond. Two Consecutive Perforations of a Peptic Jejunal Ulcer following Gastro-jejunostomy for a Perforated Gastric Ulcer.—*The Lancet*, 19th February, 1910.

Richard Roper, F.R.C.S. Edin. A Case of Spinal Meningitis Resembling Tumour of Spinal Cord: Laminectomy, Recovery.—*The Lancet*, 19th February, 1910.

R. H. Jocelyn Swan, M.S. Lond., F.R.C.S. Eng. The Estimation of the Functional Activity of one or both Kidneys. (*Illustrated.*)—*The Practitioner*, March, 1910.

J. George Taylor, M.A., M.D. Cantab., M.R.C.P. Lond. The Theory of Vaccine Therapy, with some Practical Results.—*The Practitioner*, March, 1910.

Reviews, etc.

Books for review should be addressed to The Editor, Gazette Office, Guy's Hospital, S.E. Their price should in every case be stated.

First Aid to the Injured and Sick. By F. T. Warwick, M.B., M.R.C.S., and A. C. Tunstall, M.D., F.R.C.S. Ed. 6th Edition. Revised and Enlarged. (Bristol: John Wright & Sons.) Price leather, 2s. 6d. net; stiff paper, 1s. net.

The growth of motoring, aviation, and especially of roller-skating, promises a largely increased sphere of usefulness for the "First Aid" man, or, indeed, boy-scout. As a manual of ambulance instruction, this book has an established reputation, and we recommend the sixth edition to all who desire to be useful instead of useless in those cases of serious accident which may enter into anyone's experience at any time.

Round the Fountain. Published at the *Journal* Office, St. Bartholomew's Hospital. Price, 2s. net.

This entertaining volume consists of a selection of the humorous pieces in verse and prose which have appeared from time to time in the pages of our esteemed contemporary, the *St. Bartholomew's Hospital Journal.* A few of the allusions, of course, will be appreciated only by the initiated, but most of them can be enjoyed by anyone in the "medical line." Especially, we liked "The Lay of the Primary Fellowship," and the verses called "The Lost Note," beginning:—

"I was seated one day at the bedside,
I was weary and needing rest,
And my fingers wandered idly
Over the patient's chest;
I had mapped out the cardiac dulness,
And was gently percussing the lung,
When I struck one note that resounded
Like a song from an angel's tongue."

The Comic Muse at Bart.'s, as at other hospitals, has contrived to get much fun out of cocci and other things bacteriological. There is a clever prose skit on the "Romance of the Streptococci." Another prose piece is a scathing analysis of "The Keen Man," which was quoted in these pages at the time of its publication.

Altogether, a most entertaining collection; we could have wished that the five blank leaves at the end of the volume were filled also. It should be added that the profits from the sale of the book are to be devoted to the new "Nurses' Home."

Some Books on Nursing.

We have received *Lectures on Surgical Nursing*, by E. Stanmore Bishop, F.R.C.S., and read it with much interest. We would recommend it heartily to all nurses as a most useful handbook, and a guide to surgical

nursing, especially in the gynæcological branch. We feel that the able writer has dealt in a most delightful way with his vast subject, making a great point always of the patient's comfort.

We consider it a most human treatise on surgical nursing, and are sure it will be a valuable help to both hospital and private nurses. (J. Wright & Sons, Bristol. Price 2s. 6d. net. Cloth.)

Manual of Massage, by H. A. Ellison, has reached us, and we have compared it with present editions. The manual itself is well known and has been used for some time in the massage instruction here, but up to now we understand it has not been complete, and other books of reference have been used.

We are very pleased, therefore, to find that many most valuable additions are to be found in this edition, which will be a great boon, and we strongly advise all teachers of massage to secure it for use at once. (Baillière, Tindall & Cox. Price 5s. net.)

We have studied *The Nurses' Guide to Prescription Reading* (Livingstone. Price 1s. 6d. net) with care. We understand that in large training schools such as Guy's, all nurses during their training go through a course of dispensing and prescription reading. It is considered a most important part of their training, therefore they have their own notes to refer to; but for nurses who are training where there is no course of dispensing lectures, we think the little guide would be invaluable.

Papers, etc., Received.

Hints on Prescription Writing. By James Burnet, M.D. Second Edition. (Edinburgh, John Currie.) Price 1s. net.

Brief notes on pharmaceutical Latin, incompatibility and doses; and a selection of typical prescriptions set in recent examinations.

The Medical Report of the Montreal Maternity. Prepared under the direction af the Physician Accoucheur.

"Illegitimacy." By Lady Cook (née Tennessee Claflin).

Notes on Therapeutic Sera, Bacterial Vaccines and Calf Vaccine Lymph. Under the authority of the Governing Body of the Lister Institute of Preventive Medicine. Printed and Published by Allen & Hanbury, Ltd.

Album of the Spas and Mineral Springs owned by the Royal Prussian Board of Domains. Described by Dr. Stern, Royal Inspector of Baths, Langenschwalbach. Translated by Dan Heuser, London. Coloured illustrations after original paintings.

Epilepsia. This is an international review, published every three months, devoted to the various aspects, pathological, therapeutic, and sociological, of epilepsy and kindred diseases. Original papers are published in English, French, or German, and after each paper an abstract in one of the other languages is given. Abstracts from the current literature are given in the language in which the original paper was published. The new review is under the distinguished patronage of Bechterew, Binswanger, Hughlings Jackson, Luciani, Obersteiner, and Raymond; it is excellently printed, and the London publishers are Messrs. Williams & Norgate.

Change of Address.

Roy Ellis, L.D.S. Eng., from 14, Hauteville Court, Stamford Brook, W., to 23, Henrietta Street, Cavendish Square, W. (*Teleph.* 4523 Mayfair).

J. D. George, L.D.S. Eng., from Guy's Hospital to High Street, Fishguard, Pembrokeshire.

Miss Kate Hecks, from Johannesburg, Transvaal, to the Railway Hospital, Waterval Onder, Transvaal, South Africa.

C. E. Iredell, M.D. Lond., from 41, Devonshire Street, W., to 1, Weymouth Street, Portland Place, W. (*Teleph.* 3729 Mayfair).

Dudley Kennard, F.R.C.S. Edin., from 6, Woburn Square, W.C., to 12, Bedford Square, W.C. (*Teleph.* 2565 Gerrard).

P. H. Orton, L.D.S. Eng., from Guy's Hospital to 40, High Street, Brecon.

(The Editor will be very glad to receive a postcard with notes of any change of address.)

From the Gazette's Special Pathologist.

L., MANCHESTER.—This is an inflammatory lesion affecting fibrous tissue, fat and muscle. The interior is composed of granulation tissue crowded with leucocytes, and here and there are groups of phagocytic giant cells. One prominent group surrounds what we take to be a foreign body. It looks like a piece of vegetable tissue, and suggests that the lesion is really the result of infection round a foreign body.

H.V.M., CLACTON-ON-SEA.—This specimen contains a moderate number of tubercle bacilli.

A.E.L., BUCKINGHAM.—No tubercle bacilli are detected in this sputum, which contains a little muco-pus.

G.M.J., Alton.—No tubercle bacilli are detected in this specimen, which contains some muco-pus.

THE EDITOR will, at all times, be glad to consider articles or sketches, provided that they are accompanied by the writer's name and address, not necessarily for publication. Payment is a matter of arrangement, and the fees that the GAZETTE *can offer are merely nominal, but if the writer desires any remuneration that fact should be stated. Authors who desire reprints of their papers should make their own arrangements with the printers when they return their proofs.*

A Dental Lay.

Not for the "Laity."

I.

When I was young and had no sense
I thought I'd be a dentist,
So I cadged some money from my Dad,
And got myself apprenticed.
I did a lot of dirty work,
That made me none the wiser.
I had to clean the plaster bench,
And watch the vulcanizer.
But though my work I did not shirk,
The truth I must confess, Sir,
That every piece I vulcanized
Was full of H_2S, Sir.

II.

In six months time I learnt to use
The sculptor, file, and riffler;
But truth to tell, at "waxing up"
I proved a "perfect piffler."
And when I tried to strike a plate,
It would have made you laugh, Sir;
For when I gave the zinc a tap
It always split in half, Sir.
The patients thought my plates "A1,"
So well did I prepare them.
Accounts they paid; the plates took home;
But I'm "hanged" if they could wear them.

III.

I joined a dental hospital,
As dental students do, Sir,
And when I tried extracting teeth
They always came in two, Sir.
It used to cost me half-a-crown
Each time I operated
To make the patient "hold his jaw,"
When he got it dislocated.
And when I put gold fillings in
The molars of the poor, Sir,
I always got my gold again,
For it fell out on the floor, Sir.

IV.

When to the College I went up
For my examination,
I gave examiners some bits
Of brand-new information.
For instance, when they asked me where
One found the dura mater,
I said, "On the incisors of
The sub-class endentata." (Awful!)
And when they said, "Now tell us what
You know about the Wombat?"
I said, "He wears his teeth outside,
For purposes of Combat."

V.

Now students, take my tip, and when
You try for your diploma,
Don't go and take a gumboil for
A blooming carcinoma!
And when they get you on your "bones"
'Twill prove your ultimatum,
If you mistake the mandible
For the os innominatum.
And this is law I will maintain,
So students all,—take warning!
Each man who goes through that front door,
Has a ———ed bad head, next morning.

[With apologies to the author of "The Vicar of Bray."]

Sport.

Rugby Football.

GUY'S v. CHARING CROSS.

1st Round. Senior Cup Competition.

With a strong wind blowing almost directly from the grand stand across the ground, this game was played at Richmond on Wednesday Feb. 16th, before only a few spectators, not many of whom appeared to be Guy's men. But among them was one old player who must have viewed the performance with very mixed feelings. I refer to Dr. E. M. Harrison, the old Guy's full-back of 1900 to 1904 inclusive.

When the sides lined up it was noticed that Archer and Jones were away from the Guy's team, and the absence of these men was severely felt. Charing Cross kicked off, and, after some high kicking, a huge punt by Stringer, aided by the gale, found touch advantageously. Stringer was playing in the inside position, with Covell on the wing, the latter's weak defence having much to do with this arrangement. It was a pity, rather, as Covell has not the pace for a wing man, and Stringer, as inside three-quarter, was very carefully marked. Quite early he put in a most determined run which was all but successful, Rail, for Charing Cross, an excellent forward, dribbling eventually well out of danger. Smith, of Charing Cross, a powerful full-back, absolutely cool and with a very efficacious method of handing off, was early in evidence, defending splendidly. Full of pluck, he tackled all the afternoon, and is to be congratulated on a great performance; but excellent passing beat him at last, Stokes gaining a try, and kicking a grand goal. Morris, on the visitors' right, got away after the restart, but was tackled by Stringer. The Guy's forwards were slow and appeared stale, but got the ball frequently from the scrums. Just before half-time Smith tackled Stokes when the latter was well placed, and a shot at goal from a mark by Stringer ended the first forty.

The second portion was played through in Charing Cross territory. The wind was trying, and possibly accounted for the numerous passes that Stokes failed to accept. Stringer was trying with all his might to add to the totals, and thrice in succession he ran beautifully, but the opposition concentrated on him time after time, and prevented his efforts from attaining richly-deserved success. At length Medlock picked up very neatly, and clearing well away handed to Stringer, who raced over with an unconverted try. Still Guy's persevered, but no further score was forthcoming. Once Lee looked like putting Stokes over, but Wight intercepted and got touch by the half-way flag. Roberts and Kennedy returned with a dribble, but again Charing Cross cleared; this time Williamson got off with the ball at his feet. Towards the end Charing Cross rallied, and established a footing in Guy's twenty-five, but they were unable to press home their spirited attempts at drawing up, and with play in midfield the final whistle went, with Guy's winners by 1 goal and 1 try to nil. Team:—

Guy's.—G. E. W. Lacey (back); G. C. Covell, L. B. Stringer, H. Lee, A. L. Stokes (three-quarters); J. G. Saner, C. H. Medlock (halves); G. R. Hind, W. E. Williams, A. H. Crook, A. V. Moberly, C. S. L. Roberts, W. S. Stranack, R. S. Kennedy, A. Gibb (forwards).

Referee: Mr. George Harnett.

Remarks.—The result fell far short of expectations, and the team, as a whole, must go into serious training if the cup is to remain in the Borough. The forwards must show more "devil," more dash, use very much more "boot," and they must mark their men out of touch.

GUY'S v. UNIVERSITY COLLEGE HOSPITAL.

2nd Round. Senior Cup Competition.

This tie in the second round of the competition was played under unpleasant climatic conditions at Richmond, on Friday, February 25th. Guy's, as will be seen from the names given below, had a full side out, with the exception of Archer, and for him Gibb, who has been putting in some strenuous football of late, was substituted. It was some time before the scoring began, but when it did the points were totalled up with amazing rapidity. Stringer was the first to score, after good work by Medlock and J. P. Jones. The latter player's presence seems to put new life in the side, and one hopes sincerely his valuable assistance, by example and precept, will imbue the side to its fullest extent when the final tie is played. Stringer also gained the second try; Kennedy, after dribbling cleverly, added a third. All three scores were added to by Hind, so that at half-time Guy's held the useful lead of 15 points to nil. University had striven hard by lusty defence to keep the scoring down, but the perpetual passing, carried out with surprising accuracy on the greasy turf with a ball that got gradually almost impossible to hold, wore them down. Medlock, Lee, and Stringer added more tries. Lee converted his own, and later dropped a clever goal. Stokes was next to go over, very wide of the posts; Medlock also touched down for Williams to kick a goal. Then came a nasty accident. Smith, who had been playing as "scrum half," had the great misfortune to break his right fibula. He was carried from the field, and later removed to Richmond Hospital. All will wish the injured player a speedy recovery, and in his enforced absence he may be sure he has the sympathy of all Guy's men. Not long now remained for play, so that the University team had not long to play with fourteen men, but before the end Stringer romped over again. Crook converted, and thus the final score stood: Guy's, 7 goals (1 dropped) and 3 tries (43 points) to nil. Team:—

Guy's.—G. E. W. Lacey (back); L. B. Stringer, J. P. Jones, H. Lee, A. L. Stokes (three-quarters); J. G. Saner, C. H. Medlock (halves); G. R. Hind, W. E. Williams, A. H. Crook, A. V. Moberly, C. S. L. Roberts, W. S. Stranack, R. S. Kennedy, H. Gibb (forwards).

Remarks.—The forwards were scarcely extended, but they showed much more dash than in the former tie. Stringer was in great form, while Jones, Lee, and Medlock were particularly good. If the whole team train on, the coveted Cup should be safe in its present position for another season.

Golfing Society.

In future, members may compete for the monthly medal on any day of the month, provided they notify their intention of so doing beforehand by signing their names in the book kept for the purpose in the Porter's Lodge (College), and paying 1s. to the porter. Only one card may be taken out during each month, and this must be scored on the first round of the day selected. This month, and until further notice, the competition will be played over the West Essex links.

F. D. SANER.

Birth.

WELLS.—On December 26th, 1909, at Valparaiso, Chile, the wife of Stanley Martin Wells, F.R.C.S. Edin., M.R.C.S. Eng., of a daughter.

Marriages.

BARRON—HODGSON.—On December 27th, 1909, at Bombay, Captain Robert M. Barron, I.M.S., son of the late Colonel Barron, R.A., to Hilda Maude Winnifred, eldest daughter of the late Arthur Pemberton Hodgson, I.C.S., and Mrs. Hodgson, of Dorking House, Cosham, Hants, and granddaughter of the late General Hodgson, Bombay Artillery.

WALLIS—ROBERTS.—On February 2nd, at Vale Royal Wesleyan Church, Tunbridge Wells, by the Rev. T. D. Barnes, assisted by the Rev. W. Routley Bailey of Sherborne, Charles Doswell Wallis, L.D.S., R.C.S. Eng., to Annie, younger daughter of Richard Roberts, F.R.C.V.S., of Dorset Lodge, Tunbridge Wells.

Deaths.

CLARKE.—On February 14th, at Kotona, Huddersfield, Thomas Kilner Clarke, M.A., F.R.C.S., J.P., aged 66.

ROBSON.—On January 25th, at 3, North Bailey, Durham, E. Sheddon Robson, J.P., M.R.C.S.

Ed.—A. N. C.

GUY'S HOSPITAL GAZETTE.

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Calendar of Coming Events and Ensuing Take-in Weeks.

March.

Sat. 19. 1st XI. v. Weybridge.

Mon. 21. Physiological Society's Meeting, 4 p.m.

Tues. 22. Ist XI. v. Bart's. (Final Cup Tie).

Thur. 24. Messrs. Symonds and Steward's Take-in (Messrs. Crook and Mills).

Fri. 25. Winter Session ends.

Mon. 28. Easter Monday.

Tues. 29. First Conjoint Examination begins.

Thur. 31. Messrs. Lane and Fagge's Take-in (Messrs. Mullins and Fitzmaurice).

Second Conjoint Examination begins.

Residents' Annual Dance, Wharncliffe Rooms, Hotel Great Central, 9 p.m.

Passim.

QUITE exceptionally objectionable weather prevailed on the day of the Cup Final against London Hospital, but in spite of it a most exciting and sporting game was played, and there was no lack of enthusiasm among the spectators. In spite, also, of the weather, the Prince of Wales again honoured the match with his presence, and, at the end of the game, handed the cup to J. P. Jones, who was acting as captain of our triumphant team. Last year, it will be remembered, His Royal Highness expressed the hope that he might see another contest between Guy's and London, and his wish was gratified. It was throughout a fairly and honestly contested game, and it was generally admitted that, on the afternoon's play, the better side won. For the thirteenth time Guy's has won the Cup, and the annual oscillation of the trophy between Whitechapel and the Borough, which has been regularly witnessed during the last six years, has been stopped. All our heartiest congratulations are due to our gallant fifteen and to their captain, Mr. Mullins, who was so unfortunately placed *hors de combat* by illness.

Now that so staid a journal as the *Lancet* devotes some paragraphs to hospital football, we need make no apology for the large amount of space which is taken up in our present issue by the accounts of various matches. Our football and hockey teams are just now successfully concluding a very successful season ; not all the inter-hospital competitions are yet decided, but the results so far are very gratifying, and will be welcomed by old Guy's men who take an interest in these matters, and, we suspect, invariably turn first to the end pages of their GAZETTE.

IT is our pleasant duty to congratulate Mr. G. R. Hind most heartily on having his name added to the list of Guy's International Rugby

footballers. His inclusion in the English scrum to oppose Scotland in to-day's match is as well-deserved as it is popular, and we feel sure that it will prove to be the first of many games in which he will represent his country. To anyone at the hospital who has seen Hind's football, some of the criticisms as to his size and weight which have appeared in the daily press must be very amusing. "A good forward, but on the small or light side," said one criticism. The critic can never have played either with or against him, or he would have learnt that Hind uses his thirteen stone as though it were fifteen. Added to this, his skill at "bagging the ball" and his sound tackling always make him conspicuous in any game to anyone who understands Rugby football. We are giving Hind the highest possible praise from a Guy's point of view when we say that he has proved, this year, as indispensable to the Guy's pack as J. P. Jones is to the backs.

Further congratulations must be extended to Mr. H. Archer, who has been chosen as a reserve for to-day's International.

The Residents' Annual Dance is to be held on the last night of this month at the Wharncliffe Rooms, Hotel Great Central. We believe it is the first time the dance has been held at these rooms, but their excellent qualities for dancing purposes are too well known to need pointing out here. The Countess of Bective is kindly acting as hostess, and the following ladies are patronesses of the dance :—Lady Perry, Lady Fripp, Mrs. Hale White, Mrs. Charters J. Symonds, Mrs. Arbuthnot Lane, Mrs. Newton Pitt, Mrs. Lauriston Shaw, and the Matron. The number of tickets is limited to 250, and we understand that some are still available, but early application is desirable in order that the final arrangements may be made. Tickets may be obtained from the President, or any other of the Residents, from the dental house-surgeons, or from Messrs. Moberly, Roberts, Stringer, or Sampson. For the benefit of men not yet in the wards (we still hesitate to use the unlucky phrase "junior men"), it should be pointed out that the dance is called the Residents' Dance simply because it is organised by them, but it is desired that it should be a representative hospital dance, and, as such, be patronised by men of all years, medical or dental.

The Annual Meeting of the Students' Club will be held on Tuesday next, March 22nd, at 4 p.m., in the Physiology Theatre. We draw particular attention to this fact, because we are frequently asked by members to air their grievances, real or imaginary, in these columns, whereas the proper place to air these grievances, especially the real ones, is at the annual meeting aforesaid. Owing to the multiplicity of meetings of various kinds, especially at this time of the year, there is a tendency on the part of some to take them the reverse of seriously, or, worse still, to disregard them entirely. Of these meetings, that of the Students' Club is one of the most important, for the business transacted there may affect the daily life and comfort of all its members, and any member, therefore, who has suggestions for alterations or reforms should consider it worth his while to attend the meeting in order to draw attention to them. It is also desirable that there should be a good muster of members at the annual meeting in order that a strong and active committee should be elected for the ensuing year.

Two new posts on the Staff of the Hospital are shortly to be filled—those of Aural Surgeon and of Surgeon for Genito-Urinary Diseases. The former post is to be held by a specialist holding no other appointment on the Hospital Staff, as was formerly the case; the latter is an entirely new post, and the surgeon appointed is to be in charge of the special department for genito-urinary diseases which it is proposed to start. These new appointments are the first outcome of the recommendations of a Committee which was appointed by the Court of Committees some eighteen months ago to report upon the growth of specialism in medicine and surgery, and to consider whether any changes in the special departments of the Hospital, and any modifications in the existing principles upon which appointments are made in special departments, are desirable; and to consider whether "such a reorganisation would

result in the improvement of the treatment of patients and the education of medical students."

The report of this Committee is an interesting document, as indicating the growth of specialism in medicine and surgery during the 19th and 20th centuries. For one hundred years after the foundation of the Hospital, it seems, no special departments existed—until the institution of an Ophthalmic Department in 1824. Such a condition of affairs seems almost inconceivable to us at the present time! The Electrical Department was instituted so early as 1833, the Throat Department not till 1885, the Obstetric in 1842, and so on, the last to be founded being the Orthopædic Department, which dates from 1907.

The Committee recommend that forthwith, or as soon as conveniently may be: 1. Pure specialists shall be appointed for diseases of the ear, throat, genito-urinary organs, and for orthopædics. They point out that in the case of the first three, such special skill in the use of instruments for diagnosis and operative procedure is necessary that it can hardly be expected in one who is also a general surgeon. 2. That special departments shall be created for nervous diseases and diseases of children, but that the post of physician in charge of either of these departments may be held by an assistant physician. 3. That a re-arrangement of the special beds in the hospital shall be effected so as to provide increased accommodation for these specialties. Very considerable alterations in the working of the hospital are thus foreshadowed by the recommendations of the Committee, and such changes must necessarily cause important changes and additions to the clinical appointments open to students.

The following appointments have been made by the House-Committee upon the recommendation of the Medical Committee:—House Physicians: A. E. Lees (Dr. Hale White), S. J. Darke (Sir Cooper Perry); House Surgeons: T. Evans (Mr. Symonds), T. F. Brown (Sir Alfred Fripp); Out-Patient Officers: C. H. Mills, A. L. Fitzmaurice, J. L. Johnston, M. A. E. Duvivier; Assistant House Surgeons: L. Bromley (Mr. Steward), V. T. P. Webster (Mr. Fagge), R. C. H. Francis (Mr. Rowlands), E. L. Elliott (Mr. Turner).

The Treatment of Ganglion.

The treatment generally recommended for this common condition consists of:—

a. Counter irritation.
b. Pressure.
c. Puncture.
d. Extirpation of the cyst by dissection.

Of these four methods, I have found the first useless; the second is often followed by relapse; the third is painful, and the cyst often recurs; whilst the fourth is a painful procedure, and requires, in general practice, an anæsthetic, and one's patients often cannot afford a fee for an anæsthetist.

For some time past I have been treating this condition by injecting fibrolysin into the sac, and, as I cannot find this treatment in any text-book, I thought it might prove useful to others. In carrying out this treatment, the sac is in no way emptied of its contents, but, on the contrary, it is over-distended by the addition of 1 c.c. or more of fibrolysin injected with an ordinary strong antitoxin syringe.

The procedure is as follows: the skin over the ganglion is thoroughly sterilized by washing with soap and hot water, and then well rubbing the surface with pure ether; and, finally, a pad of absorbent wool, soaked in 1–20 carbolic lotion, is bandaged on for ten minutes, this latter application making the skin practically anæsthetic. The syringe having been boiled, 1 c.c. or more of fibrolysin, according to the size of the ganglion, is injected into the top or sides of the tumour, the needle being passed in a slanting position so as to obtain some valve action of the skin. By keeping up steady pressure on the syringe, about 1 c.c. can be injected without pain in ten or twelve minutes. When the injection is finished, the needle is carefully withdrawn and the small puncture sealed with a collodion dressing; a small pad of absorbent wool is then lightly bandaged on, and the patient is instructed not to use the hand for a week. After two or three days the ganglion, when examined, will be found to be very much softer, and at the end of ten or fourteen days the tumour will have entirely disappeared. Passive movements are begun on the third day, and this is more particularly required when the ganglion is in the immediate neighbourhood of a joint.

The following short descriptions of six cases may be of interest:—

Maria H., a dairymaid, came to me with a swelling on the dorsum of the left hand, the size

of a pigeon's egg. She said she had lifted, a month previously, a heavy milk can, and "felt something give at her wrist," and noticed a swelling on the back of the hand. On examination a tense hard swelling was found involving the extensor tendons of the index and middle finger as they came under the posterior annular ligament. The skin over the tumour was carefully cleansed as described above, and 1 c.c. of fibrolysin was injected into the side of the ganglion. The puncture was dressed, and the patient told to see me next day. On examination no redness or anything abnormal was found, and the patient had suffered no pain or discomfort. Seen again four days later, the tumour was much smaller and softer. After ten days no trace of swelling could be seen or felt, and there was no stiffness in the tendons. The patient resumed her employment three weeks after the injection.

JANE C., a washerwoman, came to me with a swelling on the dorsum of the right hand. She said it had come suddenly whilst wringing out some blankets she had been washing. The swelling was on the outer side of the dorsum, and apparently connected with the extensor tendons of the ring and little finger. The tumour was irregular and flat, and about the size of a two-shilling piece. This case was treated as No. 1, except that nearly 2 c.c. of fibrolysin was injected. In three weeks' time patient had resumed her work, and she has had no trouble since.

MRS. J. sprained her left ankle some three months previous to consulting me. She said that since the accident she had noticed a swelling just below and a little anterior to the external malleolus. The swelling was so painful that she could not put her boot on, or walk without limping. The tumour was about the size of a small hen's egg, rather rounded in shape, and very tense and hard, and was in connection with the peroneal tendons. Into the swelling was injected 2 c.c. of fibrolysin. In four days' time the swelling was much softer and smaller, and at the end of fourteen days nearly all swelling had disappeared. On the twenty-first day all swelling had gone, and the patient could walk without any pain, but complained of "weakness in the joint."

CRISSIE W., aged 14, was getting over a style and slightly wrenched her left wrist, and said she felt something "give at the bottom of her thumb joint," and she noticed a swelling about the size of a filbert nut, which was very painful when touched. She consulted me some three weeks after the accident. The swelling had been painted with iodine, and attempts had been made to "disperse it." About half a c.c. of fibrolysin was injected into this swelling; after the injection some pain of a dull aching character was felt, it radiated up the arm and down to the end of the thumb, and slightly up the dorsal aspect of index finger. The pain lasted for some two or three hours and then disappeared. The swelling entirely subsided six days after the injection, and there has been no trouble whatever since.

MARY K., is a dressmaker's assistant, and was helping to lift a heavy sewing machine when she felt a sudden pain above the front of the right wrist on the little finger side. She noticed afterwards a small swelling the size of a horse bean. She consulted me ten weeks after the injury. Over the flexor carpi ulnaris, about an inch above its insertion, there was a kidney-shaped tumour about the size of a small bean. Into this swelling about half a c.c. of fibrolysin was injected. The swelling entirely disappeared in six days.

JANE B., a mill hand, works a pin-making machine. In the course of her work she has to turn a rather heavy handle, and whilst doing so the machine suddenly jammed, and the handle forcibly extended her wrist; she had a good deal of pain, and noticed a large swelling on the back of her hand. She came to me two days after the injury; over the centre of the right wrist joint on the dorsal side, there was a swelling about the size of a half-crown piece, it was irregular in shape, and very tender to touch. There was some heat also detected. The wrist was fixed in a splint, and hot lead and opium applied for two days; at the end of this time all heat had disappeared. Two c.c. of fibrolysin was injected into the swelling, and there were no bad after-effects, the whole swelling having subsided at the end of fourteen days. The patient resumed her employment on the sixteenth day after the accident.

The advantages claimed for this treatment are: simplicity; practically painless operation; certainty of action; no anæsthetic, local or general, required.

E. F. CLOWES.

Wotton-under-Edge.

Papers by Guy's Men.

A. E. Boycott, M.A., M.D. Oxon.: Peritoneal Blood Transfusion.—*British Medical Journal*, 5th March, 1910.

A. E. Boycott, M.A., M.D. Oxon., and C. G. Douglas, M.A., M.B., B.Ch. Oxon.: Further Observations on Transfusion.—*The Journal of Pathology and Bacteriology*, January, 1910.

A B.B.A. in Central Africa.

The week had been rather fuller than usual of life's little worries, with several long journeys thrown in; it was Saturday afternoon, and I sat in a lounge chair awaiting the appearance of afternoon tea, and contemplating a week-end of luxurious ease and a novel. I felt I had earned it. A native appeared on the stoep with a note as follows:—"——— Mission, 4.20 a.m. Dear Dr.—Would it be possible for you to cycle across at once? Mrs. —— is in labour. Very urgent. Yours, etc., etc." I had to decide between two alternatives:—to attempt to cycle through in the remaining three hours before dark; against this was the fact that I didn't know the way, nor how far it was, though I had an idea it was twenty-five miles; I didn't know if the rivers were passable, or if the road was negotiable by a cycle. I had had experience of this kind of trip before. Some kind friend assures you you cannot miss the way; off you go cheerfully, and after cycling some hours your Kaffir path suddenly branches into two, going in different directions. You are miles from anywhere, there is not a fifty-to-one chance of anyone coming to advise you; you toss up, take the wrong road, find yourself at dark lost in the bush with no food, no blankets and no weapons; just about the most cheerful prospect one can run up against.

I lost some time trying to find the two other residents on the station, in order to find out something about the road. They were both out shooting, so I determined to adopt the second alternative, that is, to go slowly but more surely, and take native guides. By the time I had collected what I thought necessary to meet any emergency, got into trekking garments—shorts and putties for ease in travelling not to be beaten—had a cup of tea, an hour had elapsed, and it was a quarter to five.

The natives who had brought the message, as it turned out later, had already done thirty miles, but they started off at a good pace, in fact, as quickly as the path permitted me to travel on the bicycle. In two hours it was getting too dark to cycle, but I congratulated myself we were well on the road. Then my troubles began; darkness came, and I had to give my cycle to a native. The darkness was such as I had never yet experienced; it was the wet season, and the sky was cloudy, and we were marching through a forest. It was so dark I could not see the native leading the way a few yards in front of me. I put a boy dressed all in white in front, but kept losing even him. Still we stumbled along—running into trees, falling over ant heaps, and I got a cut under the eye from a sharp bamboo. I instructed the native carrying the bicycle to leave it in the bush. The strain on the eyes was very irksome, always trying to penetrate the intense darkness. The natives kept losing the path which it was impossible to see. They found it again by shambling backwards and forwards across our direction, feeling for it with their feet. I learnt they were keeping the path entirely by a sense of touch, and essaying to do likewise succeeded to a certain extent, which relieved the eye strain considerably, for feeling your feet on the path gives confidence, and you are not always straining to see some invisible obstacle. I began to get sleepy, and could have rolled up in my blankets and gone to sleep willingly anywhere, till it began to rain. That woke me up; I was soon wet through and cold, and getting a shower bath from every tree. We arrived at a kraal; the natives requested permission to go inside and get warm over the fire. I remained outside shivering, and consulted my watch; it was 10 o'clock; two hours cycling 12 miles, three hours walking 9 miles—if the total distance was 25 miles, as I thought, then we should soon reach our destination. I inquired of the natives when we should arrive. They replied, "At dawn." I thought they were lying—a favourite trick in order to persuade me to stop the night at the kraal. I left my bicycle boy behind with instructions to fetch the bicycle and bring it on to the Mission in the morning.

On we went, the monotony of the journey unbroken save by frequent halts to find the path and a plunge knee-deep through our second river. At 1 a.m. we arrived at a second kraal; again my natives requested to be allowed to warm themselves and cook some food. A miserably small fire was made with damp wood, and round this we crouched, the cold shivers playing up and down my back. The natives smoked a hubble-bubble pipe in turns, and ate their porridge. I had never thought the act of eating could be so disgusting or noisy. I took my first pull at my flask and a comforting pipe. I had been at queer supper parties, embracing Lockhart's, the coffee stall, and many another queer place known to students, where the company, to say the least, is mixed. This was a new experience. Half an hour later we went on, and arrived at our destination at 4.30 a.m., just twelve hours all but a quarter from the time of our setting out; we were wet through and miserably cold. One thing I did congratulate myself on—not having attempted to cycle through before dark.

The patient was doing well, the child had been born about forty minutes after the message had been dispatched. It was premature (about ten weeks* according to the parents), and very small; we couldn't get it to turn the scale at four pounds next day, but I felt sure this was not correct. As neither mother nor child required my attention, my thoughts turned to something hot with whisky in it, and getting between the blankets. The kettle was put on, but the fire, owing to the dampness of the wood, did not make much of a show. The missionary and his wife lived in one very large commodious round hut which served as a living and sleeping room. To my anxious eye it did not seem to reveal any sequestered corner where I might get into dry things, so I sat in front of the fire and shivered. However, an invitation to wash revealed a separate compartment,

* Thus in the MS. It must be remembered that we are dealing with Central Africa.—Ed., G.H.G.

and when I had put on dry garments, the coffee was ready, also food, which I did not in the least fancy. However, after my first cup of coffee, which had something in it, and washed down ten grains of quinine, I began to feel a bit peckish, and selected from the menu bread and cheese, a somewhat queer choice, as I rarely touch cheese.

A 5.30 a.m. I was informed there was a bed waiting for me, and I gladly turned in. I was up again at 8, and saw my patient and the child, who were both doing well. I saw a few other native patients, and then began to think of getting home. It was obvious if I waited till my bicycle arrived I couldn't get back that day, whereas if I started at once I could walk through if I didn't meet the bicycle. There was an anxious wife at the other end, and when you dwell in the back of beyond, you don't stay away from home a second longer than necessary.

It was 11.30 a.m. when I started back; I was rather stiff and sore, but I knew this would wear off. I saw two or three herds of buck in the distance, a sight which would have gladdened my heart on any other occasion, but on this I would not leave the path, but admired them from afar. Wherever there was water there were also snipe in abundance, who, with the peculiar instinct of sporting animals, circled round me perfectly conscious of their own safety. At 2 p.m. I suddenly came across the spoor of my bicycle, proving my boy had passed with it, but had taken another route, and we had missed him. I sat down and fired two shots with my rifle on the off-chance he might be near enough to hear and return, and waited half an hour. As he did not, I set out to walk home. This was the most trying part of the day; it was excessively hot, my feet became sore and showed signs of giving out, and the stiffness had not improved to the degree anticipated, and many weary hours lay in front, and the possibility of not being able to see it through kept presenting itself and had to be sternly suppressed. Thirst became excessive—not an ordinary South African thirst this, which can be and is better left unsatisfied till the end of your journey; it was a thirst that would not be denied, a bodily craving for water, and one became aware how precious were the contents of the water bottle, and began to apportionate them; a little drink at 4 o'clock, and then not another till 7, and so on; it made something to look forward to, something to break the monotony and stop the ceaseless mental calculation that would go on, and which was disheartening, as it always brought one to the same self-evident fact, that half way had not yet been reached, and would not be till 5 p.m. Between 3 and 4 I became convinced my watch had stopped. The pipe, which had proved a boon companion during the night, and greatly lessened the length of the passing hours during the heat of the day, was not permissible, as likely to increase the thirst and spoil the wind. Then came a pleasant shower of rain, the going became cooler and pleasanter: five o'clock was passed, and each hour accomplished was one hour nearer home. The mind now began pleasantly to anticipate exactly what one would eat and drink on arrival home, to imagine just how delightful the warm tub, and to sit luxuriously at ease in a lounge chair, would be. This was a pleasant change from the mental calculation mentioned before, and a wretched couplet that had been running in my head all the day and previous night ceased to be obtrusive; I even gave up the effort to remember how it went on, and don't know to this day. The couplet, "One step before another and the longest journey's ended." How *does* it go on?

At 7 o'clock we had arrived at a river I knew was ten miles from home, and I was quite cheerful and fit, and not particularly fagged. But the worse was yet to come. Without warning down came the rain, and heavens, how it rained!—mercilessly, relentlessly beating against us as if it had some personal spite. And with the rain came darkness, great and awful darkness, the darkness of a plague. Compared with this, the previous night had been light. I couldn't for a second keep touch with the native in front, and only succeeded in following at all by holding an assegai of which he held the other end. How we followed the path at all to me was a mystery. And all the time it rained. We were all wet through to the skin and terribly cold. The speed at which we could travel was not sufficient to keep us warm. I began to wonder what the penalty would be, as chills like these in the tropics are not without danger. The previous year had brought enough sickness to last me a long time, including as it did two bad attacks of influenza and one of pneumonia, and the sudden collapse of a big mine which practically constituted the practice in which I had sunk my little all, had brought the exchequer to a state which made the possibility of illness far from pleasant.

Then the native sent from the Mission to guide me, though only having done the one journey, started to whimper and cry. He was suffering from "the hunger and cold," he said. So was I. I put him behind and went on, but after that we had to keep waiting and calling for this straggler, and time after time I thought he had collapsed, and we should have to return for him, when out of the darkness came a distant voice in reply to ours. With the advent of the rain, whether from the tonic effect of the cold, or the counter-attraction of other discomforts, all soreness of the feet and all tiredness and stiffness of muscles entirely disappeared or were forgotten. The only sensation seemed one of intense cold.

I arrived home at 10.30 with teeth chattering; the warm bath was not available owing to every particle of wood being utterly soaked; but the other luxuries so long anticipated were soon forthcoming, together with a ten grain dose of quinine. I didn't get warm till I had been in bed for some hours, and I had a most uncomfortable night, perhaps owing to the lack of the necessary warm bath, the muscles of the feet and legs became positively painful, and in my broken dreams I continually and for ever followed a narrow native path, with impossible winds and curves.

The next day I just slacked, but the day following took up the ordinary routine of life.

By a strange coincidence I had just been reading in the Guy's Hospital Gazette of a twenty-four hour walking race, and the writer had laid stress on the fact that the competitors suffered from mental distress, and music had been provided to relieve the monotony of the night hours. It is undoubtedly the monotony of the long hours that gets on one's nerves. I happened to be in the best of training, and had been in the habit of spending from four to six hours two or three times a week on the veldt shooting, for we have no butchers' shops in this part of the world, and we depend entirely for food on what I can shoot, and game had been scarce.

When in good trim it's astonishing, once you get into your stride, how far you can walk without excessive fatigue, even in the tropics. When I arrived home, physically I was fit enough for a good many more miles had it not been for the excessive cold. As the writer of the article laid some stress on the diet during the race, I may mention that I only ate some sandwiches *en route* going, and a few biscuits on the way back. I had one mouthful of neat whisky followed by a drink of water going, and one ditto when nearing home, as with the excessive cold I began to feel inclined to vomit. The journey was well over sixty miles; I was away from home under twenty-nine hours, twenty-one of these were actually spent in trekking, and about four hours in resting, the remainder working.

All travelling in this part of the world is done on foot. An average daily trek is from fifteen to twenty-five miles, and the pace from three to three and a half miles an hour, according to the road. When one has to travel a distance of hundreds of miles, the hours of trekking become excessively monotonous.

Ndola, N.W. Rhodesia. P. H. WARD.

Dental News.

The Conservation Room will be closed from Thursday evening, March 24th, at 5 p.m., to Wednesday morning, March 30th, at 9 a.m.

The last meeting of the Dental Society's present session was held on Friday, March 18th. The subject under discussion was our hardy perennial, "That this House considers that the present method of training the Dental Student is antiquated." The motion was proposed by Mr. H. E. Shepherd, and opposed by Mr. F. Bocquet Bull. Fuller details of this meeting will appear in the next issue.

The Annual Meeting of the Society will take place on Thursday, May 19th, at 3.30 p.m.

The following appointments have been made by the House Committee, upon the recommendation of the Dental Council:—Assistant Dental House Surgeons: E. O. Yerbury, H. F. Barge, A. G. Poock; Assistant Demonstrators in Dental Mechanics: G. B. Pritchard, G. W. E. Holloway; Assistant Demonstrators in Dental Metallurgy: P. B. Stoner, J. H. Rhodes; Assistant Demonstrators in Dental Microscopy: H. O. Salt, C. H. G. Penny.

Guy's Physiological Society.

A meeting of the Society was held on February 28th. Mr. Ryffel was in the chair, and forty-three members were present. Mr. Richards read an interesting paper on "The Digestion and Absorption of Food." The author dealt with the secretions poured out, and their action on the food, in the order in which they severally took part in digestion. Secretions are poured out in saliva and gastric juice, having a composition which is regulated in quantity and composition as required by the food taken. These secretions are produced both by psychical and physical causes. Thus in sham feeding a secretion is obtained from the stomach when no food reaches it. Pure mechanical stimuli, however, will produce no secretion. Pancreatic secretion is caused by the entry of food into the duodenum, and is set up by the acid which forms the secretin. There is only very slight psychical secretion produced by the pancreas. The action of the bile is chiefly to help in the digestion of fats. Absorption takes place chiefly from the small intestine, water being eliminated by the large intestine. Practically no absorption takes place from the stomach.

A meeting of the Society was held on March 7th. Mr. Kennaway took the chair, and thirty-seven members were present. Mr. Barrow-Clough read an interesting paper on "Internal Secretions." He mentioned that internal secretions contained hormones, which, being carried by the blood-stream to different parts of the body, played a very important part in general metabolism.

The complete removal of thyroids and parathyroids is fatal, whilst in many animals the removal of thyroids alone has little effect. Insufficiency of thyroid secretion produces myxœdema, tetany, and cretinism, which can be remedied by injection of thyroid extract.

The pituitary body has an anterior and posterior lobe and a pars intermedia, of which the anterior and posterior lobe are most active. Disease or removal of the pituitary cause a condition of acromegaly and also disturbances of the sexual functions. Its effect on plain and cardiac muscle is the same as that of adrenalin, except in the fact that it causes renal vaso-dilatation.

Thymus has very little importance, the loss of it being attended by no marked evil effects. Loss of it, however, tends to lessen the resistance to disease, owing to an insufficient formation of leucocytes.

The suprarenal capsule has two definite secretions, a cortical and medullary. The cortical secretion seems to control the development of sexual characteristics, whilst the medullary seems to act by keeping up the tone of the muscular tissues.

Loss of internal secretions from the testicle, caused by castration, prevents the production of secondary sexual characteristics and produces abnormal growth in the size of the individual. It also has some power in maintaining the general vitality of the body.

One-Sided Conversations.

A Compulsory Appointment.

"To A. Nutt, Guy's Hospital.—

"Meet you 2 o'clock to go over Hospital.—

Phyllis."

. . . Don't mention it, it's only a quarter to three. . . Yes; it's quite straight. . . Is it? I really hadn't noticed—er, at least I thought I had seen it before. This is the Colonnade. . . . Do you? I don't admire that type myself. . . . I don't know him, so I really can't say. . . . No, they ar'nt doing nothing; they're waiting for the surgeons to come. . . . Oh, a long time sometimes. That's the Park. . . . Because it's not in the least bit like one, I suppose. . . . That's Clinical; all the most interesting cases go in there. . . . Yes, some of them do—quite a lot, in fact. . . . Oh, no, they would do anyhow. . . . Not yet, but I may be some day. . . . They're just going on duty again. . . . Oh, those in blue are sisters and the others just nurses. . . . I don't know; something to do with the matron, I think. . . . Yes, it is to some types. . . . No, that's a ward-maid. Here's the Museum. . . . All right, I couldn't possibly know; I thought it would interest you. . . . No, we won't see anything more like that; here's the Physiological Laboratory. . . . No, we don't torture anything. . . . Yes, it is a cat. . . . Do you? I think it looks quite happy for a cat. . . . I told you it's *not* going to be tortured. . . . *No*, it just lives there; that's Dr. P., the famous physiologist. . . . Do you? I think he's got a very kindly face. . . . No, *he* doesn't torture anything either. . . . I havn't read it, and I don't want to. . . . Well, I didn't mean to be rude; let's change the subject. We'll go and see one of the medical wards; just step in here, will you? . . . You just press the button. . . . Yes, very often. . . . Oh, just wait till someone comes and puts it right. . . . Oh, they have to wait as well, if they're in it. . . . No, they can't hear it, and it won't shut if you don't. . . . Well, I don't suppose it disturbs them, anyway. . . . Yes, she does look rather ill. . . . An appendix, I think. . . . Yes. . . . Not a very serious operation. . . . Oh, quite a lot. . . . No, you soon get used to it. . . . Oh, they're put round the bed because that patient's very bad. . . . I expect she will. . . . Of course, someone does. . . . No, *I* can't do anything . . .? because it's not my business, of course. . . . I suppose it does rather. . . , Well, they *will* cry, won't they? . . . No, I don't think so; I thought it was a habit of babies. . . . No, I tell you it's nothing to do with me. . . . Yes it is, but we've all got to die some time. . . . No, I don't think I am, but it's a fact all the same. . . . All right, we'll go down to Out-patients. . . . Yes, it is pretty bad, isn't it. . . . They *are* open. . . . Well, you couldn't have any more. . . . Yes, they're not over clean, are they? . . . I don't know—partly to keep warm and partly from laziness, I suppose. . . . It's impossible. . . . There isn't time; it would take all day to wash them. . . . Very well, let's go through into the Front. . . . That's the Surgery . . . Because it used to be in the front, and now it's at the back. . . . Oh, some accident, I expect. . . . I don't know. . . . No, *I* can't do anything . . . Because it's not my business. . . . Of course, some one will. . . . Oh, in a few minutes. . . . No, *I can't*. . . . Because, as I said before, *it's not my business*. . . . No, I'm not, only you can't have everyone interfering. . . . Yes, it's five minutes to. . . . Must you really? . . . Not at all; I'm glad you found it interesting. . . . Yes do, any time you like. . . . Good-bye. . . . *Thank Heaven!*

A. NUTT.

Pass List.

University of Cambridge, March, 1910.

Degree of M.D. Conferred.

Charles Derwent Edwards, St. John's.

Chapel Notices.

HOLY WEEK.

Monday, Tuesday, Wednesday and Thursday: Holy Communion, 7 and 8.45 a.m. Short Service and Address, 8.15 p.m.; Preacher, Rev. E. A. Edghill, Sub-Warden of the College of S. Saviour.

Good Friday: Litany and Meditation, 7 a.m.; Matins and Ante-Communion Service, 9 a.m.; Three Hours' Service, 12—3: conducted by the Rev. E. A. Edghill, Sub-Warden of the College of S. Saviour.

Easter Day: Holy Communion, 6, 7, and 8.45 a.m.

W. A. DUNN, Acting Chaplain.

A. H. SMITH, Assistant Chaplain.

Lacerated Wound of Knee-Joint.

CLINICAL LECTURE BY Mr. SYMONDS.

Gentlemen,—A boy of 12 was admitted on Wednesday with a lacerated wound of the knee-joint. He sustained this injury by falling upon a sharp stone four days before while tobogganing.

The lad was seen soon after the accident, and the wound examined. As it was recognised that the condition was serious a general anæsthetic was administered, and the wound examined, the result of the investigation being that the patellar bursa had been opened, but that the joint itself was uninjured. The wound was cleaned, closed by two sutures, a rubber drain inserted, and the limb placed on a back splint. Suppuration ensued, with some rise of temperature, and, fearing that the joint might be implicated, the boy was sent into the hospital for further treatment.

On admission there was swelling and œdema of the superficial tissues; pus oozed from the wound, and flowed when pressure was made over the joint. No union had taken place, and there could be no doubt that there existed suppuration under the deep fascia and probably in the joint as well. There was very little pain, no distension of the joint, little constitutional disturbance, and one hoped that the joint was unaffected.

Accuracy as to the condition being essential, the boy was placed under ether and the wound examined. A pocket tracked upwards and backwards, indicating, no doubt, the detachment of the structures at the time of the injury. An incision was made on the side of the knee at right angles to the wound, and the cavity laid open. Then pus was seen oozing from the cavity of the joint, and escaped freely on pressure. The margin of the patella had been sliced off by the stone, and there was an irregular gap in the capsule through which the little finger entered freely. It was quite clear that we had a severe condition to deal with, and a joint that had been suppurating for some days. The opening in the capsule was enlarged upwards so that the synovial membrane could be seen. It was swollen as it covered the bone, red, succulent, and bathed with pus. To its surface flakes of lymph adhered, and many similar flakes were washed out.

What is the best way to deal with a joint in this condition and at this stage?

Let it be noticed, first, that the joint was freely suppurating, the boy was not so ill as one would have expected, nor was there the amount of pain and œdema one is accustomed to associate with such a condition. The absence of these symptoms may be attributed to two conditions: first, to the effect of the germicides employed when the wound was cleaned; and, secondly, to the large opening permitting the escape of secretions. The virulency of the infection is so much mitigated owing to the use of germicides that we must expect a mode of infection, and so a clinical course of the case of a much milder type than formerly.

A large irregular wound now resulted, freely suppurating on its deeper surface, and at the bottom a free opening into the capsule. The cavity was irrigated with saline, and by means of a silver catheter this was carried between the bones. Then perchloride of mercury gradually increased up to 1–1000, and finally saline. Though the infection was of some days' duration, and the synovial membrane was already swollen, I decided, on account of the comparatively mild infection, to dispense with a counter incision and drainage. The wound was plugged with iodoform gauze and the leg ordered to be placed in a plaster of Paris splint (a Croft).

On Saturday the boy was not so well; there was a rise in the temperature; he had a good deal of pain, especially at night, and pus came freely from the joint. My house-surgeon, finding that suppuration was increasing, thought it better to apply boracic fomentations and retain the back splint.

Further drainage becoming advisable, he was anæsthetised and a free opening made on the outer side and the joint again irrigated. The synovial membrane was thicker and more vascular than before, the divided tissues swollen and purulent, and the prospects of anything but a stiff joint looked small. A rubber drain was inserted into the joint from the outer side, but not brought across through the inner opening. The inner and suppurating wound was plugged with gauze, an abundant dressing applied, the whole limb enclosed in wool, and a Croft applied from the gluteal fold to include the foot. The leg was then swung in a Salter's cradle. In this way the greatest amount of rest—an essential feature of the treatment—is obtained.

The alternative method is to apply an excision of the knee-splint retained by a pelvic support. This does not involve movement of the leg for the dressing, and will be applied if suppuration increases and frequent dressings become neces-

sary. I am in hopes, however, that the joint infection may be arrested.

At the next dressing a solution of citrate of potash, 3 per cent. in a saturated saline, will be applied.

One further method is suitable in a case of this kind, viz., continuous irrigation. This we can resort to after the metal splint is applied. It means ankylosis as a certainty, and I am therefore loth to employ the method while there is a prospect of arresting the suppuration by other means.

Why did the joint suppurate, and how could it have been prevented?

Had a free examination of the wound been made, the laceration of the capsule must have been seen. The full extent of the injury was not recognised, and it was thought that the serum came from the patellar bursa. You will remember that the wound was a transverse one, reaching from the lower border of the patella along the inner side for one and a half inches. The edge of the patella had been sliced off.

In all such injuries you must first recollect that there is subcutaneous laceration. The force driving upwards lifts the skin, and if the injury be inflicted by a penetrating body, as in this case, it involves the deeper structures to a greater or less depth, so that at the bottom of a deep wound there may be an opening in the joint concealed from view by the approximation of the parts.

It is essential in all lacerated wounds about the knee to ascertain the extent of the injury, and, above all, whether the joint be involved. A probe will often fail to give this information as it becomes entangled in the lacerated muscle and other tissues. There is only one safe method to avoid uncertainty, and that is to enlarge the skin wound if necessary, and that in the deeper structures, and expose every corner of the cavity. This being done, the opening is visible if it exists. It may, however, be a slit with margins in contact, and in these cases move the joint, so as to separate the edges of such a wound. Synovia will escape as a rule, and the aperture be recognised. In this case a vertical incision carried upwards from the lower end of the laceration would have exposed the rent, which was large enough to admit the little finger.

Having recognised the injury, how should the case be managed? The skin all round will be scrubbed and shaved for six inches at least above and below the wound, the wound itself cleaned first with saline, and then with perchloride of mercury or carbolic acid. While this is being done keep the knee straight, and let a pledget of iodoform gauze close the opening into the joint. Having, in addition, removed adherent particles of dirt by cutting away the skin margins or portions of muscle and fascia, the great question next comes what to do with the wound of the capsule and the joint itself. On this point there may be some difference of opinion. I will describe the method I have found give good, if not the best, uniform results.

Lacerated wounds do not heal by primary union unless a very free removal, practically an excision of the wound, be made; even then one cannot be sure that all infective material has been removed.

Therefore I would complete the dressing of such a wound by packing it wth iodoform gauze and applying a plaster of Paris splint (Croft) as giving the greatest amount of rest. The first dressing will be made in forty-eight hours, and others at similar intervals. A small wound and a clean one will require two or three dressings. Then, when clean, the gauze is dispensed with and the wound closed. A dirty and large wound may require four or six dressings.

In this account you will notice that I have not irrigated the joint. This important question requires separate consideration. It is unnecessary to irrigate when the wound is small and the deeper part clean, as I will show you by examples, provided you get the case early.

Irrigation is unnecessary where the wound is inflicted by a stone, or some ragged body like a piece of tin, or iron, or by a piece of glass; that is to say, when the cut in the capsule is clean and when the edges are free from bruising, as is usually the case.

A child of ten was admitted with a lacerated wound inflicted by a piece of tin. The deeper part of the wound was, owing to the oblique penetration, an inch or more above the skin opening. A free incision exposed the deeper part and also a perforation into the joint. The wound, being cleaned, was packed with iodoform gauze, the joint not being interfered with. At the end of four days the wound, being clean and granulating, was brought together, complete freedom of movement being secured.

Take another case, where great risk was run through closing the wound. A woman of 55 was run over by a cart and a flap of skin torn from the inner side of the right knee. The house-surgeon of that time cleaned up the wound, looked for, but did not recognise, an injury to the joint. The flap was sutured and drained. Next day when I came round and saw this case, not being satisfied with the evidence,

and holding that all such wounds should, if doubtful, be treated by open dressing, I had the sutures removed. At first it looked as if the joint had not been opened, but on flexion the semilunar cartilage was seen, and synovia escaped. A portion of the capsule had been torn off and the joint cavity exposed.

At the moment there was no effusion into the joint, and no septic absorption; the wound treatment had been effective. Iodoform gauze was applied, and the flap allowed to fall away. It was necessary to see such a case frequently so as to irrigate the joint the moment signs of septic effusion occurred. In twenty-four hours the joint was full of fluid, the capsule well outlined, and the condition looked dangerous. There was, however, no redness, little, if any, tenderness, the temperature had not risen, nor was there any disturbance of the circulation. I therefore redressed as before, and decided to wait. The effusion might be of a serous and non-infective variety. Next day the joint was smaller, and thus, forty-eight hours after the onset of effusion, the danger of suppuration had passed. The wound healed, leaving some stiffness for a time, due to the cicatrisation of the capsule and of the skin, for the flap sloughed.

In this instance there can be little doubt that the joint would have suppurated had the flap been left. Note also that even where the capsule was torn and the semilunar exposed, good recovery resulted without irrigation.

My advice, therefore, is not to irrigate as a routine practice when the injury is obtained early, and not to suture the capsule. I by no means intend to infer that suture is harmful, and that in clean wounds it might not be done, but I would maintain that in a lacerated wound it is unwise, and that in incised wounds as good and as quick result will be obtained by an open dressing as by suture. If the capsule be sutured, then, in my judgment, it is essential to pack the rest of the wound.

Irrigation must be employed when the deeper part of the wound is dirty, when you can see infected material in the joint, and when there is blood or serum distending the articulation. Again, it must be carried out when the case is seen late, say after one or two days, and also where the capsule has been torn away.

The best immediate treatment, while making fuller preparations, no doubt is to fill the wound with sterilised gauze wool or lint saturated with perchloride of mercury solution (1–1,000) or with carbolic (1–40). Such a dressing was applied to a case I saw some years ago where the ankle-joint was opened by a Pott's fracture and a good result was obtained. In the very next case the bath sponge was applied and bound in. Better have left the joint to the mercies of the air—still, even this case did well.

This primary dressing can fortunately always be obtained, for lint and wool can be boiled in a few minutes and used without the antiseptic agents. On one occasion I prepared a handkerchief and plugged the wound. You must not delay applying a dressing because you are without your usual outfit. Employ some substitute that will be at least aseptic, will prevent bleeding, will check the entry of infected serum into the joint and the escape of synovia, till you can deal with the wound on appropriate lines.

To show you how much can be done to save a limb if a joint be managed on these lines, let me refer to the case of a man run over by a heavy cart. The wheel crushed down the inner side of the knee, carrying away a large flap of skin, a portion of the capsule, and shaving off the surfaces of the condyle of the femur and the tuberosity of the tibia. Unfortunately this man did not come under my notice for twenty-four hours after the accident; already septic changes had taken place, and to such an extent that foul-smelling serum could be squeezed from the joint. The man was about thirty, and though one of the hard-working poorly-fed class, was yet strong and wiry. Immediate amputation was indicated, while excision, a second alternative if seen at once and before septic changes ensued, was, in the presence of septic changes, unsuitable and dangerous.

An attempt might, I thought, be made to save the man's limb by adopting the line of treatment I have described to you. The tissues, ingrained with dirt from the cart wheel, were cut away, the bone shaved with a chisel, and the joint irrigated. About half an inch of bone had been removed by the wheel, the cartilage on both surfaces being cut through. The irrigation began with saline, then continued with a gradually-increasing strength of perchloride of mercury up to 1–500, passing again to saline. A pad of iodoform gauze was laid on the bone (for you will recall that the capsule had been torn away), an abundant dressing applied, and the limb put up in a Croft. Though healing was slow, and it took some time for the joint to ankylose, a useful limb resulted. There was no rise of temperature, no pus formed in the outer or back part of the joint. The bone granulated and the wound was later closed by grafting. This was a severe test for irrigation and the omission of drainage tubes, and had it not been for the actual removal of bone and capsule a movable joint might have

resulted. If I had seen this man immediately after the accident I should have excised the joint as a means of shortening the period of healing.

Let me refer to a case under my care some years ago, where, though seen early, suppuration occurred. The wound was a small one; it was examined by my house-surgeon and dresser by means of a probe, carefully, for fear of entering the joint. They concluded that the joint had not been opened, put in a superficial drain and applied a splint. All went well for a few days, then my attention was called to the case; and I must here confess that, relying upon the result of the examination made at the time, I did not at once recognize the severity of the injury. Suppuration took place, the joint was opened, irrigated and drained, and ankylosis resulted.

It was this case that led me to give directions how these cases should be treated. Very soon after there came in the child referred to earlier who was injured by a piece of tin.

Let me conclude this part of my lecture by insisting upon the necessity of making quite sure as to whether the joint is, or is not, opened. This you must do first by opening the wound so as to see into its deepest parts. A probe is no good at all, it catches in the tissues, and gives fallacious information; above all, do not be afraid of passing a sterilized instrument into a joint. It is this fear—a relic of former days—that leads to imperfect investigation. If you do not at once recognize an opening, then move the joint; this may open a slit-like aperture and permit the escape of synovial fluid.

While cleaning the external parts, plug the wound with some antiseptic gauze to prevent the entrance of water and septic materials removed from the skin; and when cleaning the wound itself, plug the deeper part with the same object.

Finally, when you are called to a lacerated wound about the knee, or any other joint, pack it with antiseptic gauze, wrung out of some kind of lotion, or, if this be not available, then with wool or lint soaked in 1–1000 mercuric chloride or 1–40 carbolic acid. If none of them be available, boil a piece of lint or handkerchief and use this. In other words, secure the removal of infected serum and blood, and prevent its entery into the joint. In the final treatment my advice to you is: never to suture these wounds at the first dressing.

We come back to this boy. It is a week since he came in; you see the swollen condition of the joint, the prominent red bleeding granulations, the free escape of pus. Notice that he is wasting, that the temperature is up to 101° at night. What is in the future? I hope that by free irrigation and careful fixation we may save the limb.

It may be necessary to make a counter opening, and pus may form in other parts of the joint and require evacuation. Should the boy run down from broken sleep, pain, and septic infection, we must amputate. So long as there is no secondary deposit, *i.e.*, no pyæmia—and this is not likely to occur—we may wait so long as he takes his food well. Septic changes necessarily accompany the removal of cartilage and the destruction of the joint, and the boy will bear a good deal. We know that even if he gets pretty low amputation will remove all disease, and that recovery will follow rapidly. You see him to-day soon after a severe operation with the limb in a plaster of Paris splint. I may add here that this splint gave the boy immediate relief. I fear daily dressings may become necessary; if so, we will apply this splint used after excision of the knee by Sir Henry Howse. You will notice that there is an interval left for dressing, a bar supporting the joint behind. The limb will be supported in a cradle.

Note.—For ten days the lad's condition gave rise to anxiety, and on account of the continued pyrexia, the loss of appetite and rapid wasting, the parents were warned that amputation might be required. The excision splint was applied, and the dressing was changed daily, and the joint irrigated with saline. An abscess was opened on the outer side over the tibia. By the end of three weeks he mended distinctly, and the temperature came down to normal. The joint will be stiff, but a useful limb will result.

Appointments.

Civil.

Golding-Bird, C. H., F.R.C.S. Eng., has been re-elected Representative of the Royal College of Surgeons of England on the Central Midwives' Board.

Kolaporewalla, P. J., M.R.C.S., L.R.C.P., has been appointed House-Surgeon to the Free Eye Hospital, Southampton.

Naval and Military.

Colonel H. J. W. Barrow, A.M.S., Principal Medical Officer 3rd (Lahore) Division, is granted leave out of India for ninety days from April 8th.

Surgeon K. H. Hole, R.N., has been appointed to the *Russell* on recommissioning, March 22nd.

Lieutenant Malcolm Leckie, R.A.M.C., is seconded for service with the Egyptian Army, February 21st.

Guy's Hospital Debating Society.

THE last debate of the Session was held on March 12th. Dr. Spriggs took the chair. The subject of discussion was: "That in the opinion of this House nationalisation of the medical profession is desirable."

Mr. N. MUTCH proposed the motion There was a conspicuous lack of co-ordination in the complex organisation of the medical profession. Its functions were intimately bound up with the social structure of the community; any attempt to weld the profession into a uniform whole involved problems in political and social economy of more than medical interest. The defects in the present system were obvious from every point of view. As public opinion had become unable to suffer destitution, attempts had been made to afford relief. So far these attempts had resulted in the establishment of a heterogeneous army of officials whose work overlapped in every direction. The poorer classes formed the most diseased section of the community; to deal with these the Poor Law and Public Health authorities, as well as voluntary institutions, had striven—but in a manner so inco-ordinated as to merit the condemnation of a recent Royal Commission. Their only good effect had been to demonstrate the glaring defects of such a system. The natural selection argument was futile and without foundation. The Poor Law medical officers were elected with a regard to economy, and that alone. A cheap scale of payment was accepted by the doctor with ulterior motives; whilst in accepting a wretched salary he felt justified in neglecting the patients. Medical orders were given by a non-medical relieving officer. The poor would only seek relief at the last pitch. There was inequality of treatment in different localities. The unequal social status of the people relieved called for the gravest objections. All the institutions were understaffed. Finally, the Poor Law system afforded no opportunity for the promotion of medical science and sanitation. The Public Health authority, though based on sound principles, was under-developed and overlapped by other administrations. Voluntary treatment was subject to abuse by the well-to-do classes. The out-patient system was an anachronism and useless from the curative aspect; in it, prophylaxis was impossible. The Medical Mission in many cases meant qualified quackery. To deal with such widespread evils as phthisis and venereal disease, educative, curative and preventive institutions were essential. The general practitioner had been reduced to a degrading position; he found it necessary to pamper his patients rather than to minister to their true needs. The humanity-serving ideal was being replaced by a struggle for bare existence. Medical education and research was in a hopeless condition through lack of organisation; a man was unable to devote his whole time to the investigation of medical science; he must first earn sufficient money by the practice of medicine or in other ways. The remedy for all these evils lay in nationalisation. No definite scheme had yet been proposed; co-operative elaboration was necessary. The outlines of a scheme might be suggested, however. The general organisation should include administrative units of county dimensions, a central board of control, and elected bodies, such as County Councils. The latter should have full opportunity for observation and criticism, with free access to the central authority, but no direct administrative power. The general practitioner would form the unit; he would be held criminally responsible for all the lives in his district, and would treat the patients or transfer them to a surgeon, specialist, or various institutions, such as sanatoria, asylums, or research hospitals. He would work in strict conjunction with health visitors and nurses, sanitary inspectors and relieving officers. The whole service would be State-paid. All treatment through the medium of the general practitioner for the district would be free. Fees would be charged for a choice of general practitioner, or for direct admission to a specialist without a general practitioner's recommendation. Funds would be raised by taxation proportional to income, and rates to reach the moderately well-to-do working classes, also by fees for the privileges mentioned. Medical research should be endowed and organised around the existing medical schools and hospitals. Hospitals should also be used for the investigation of obscure cases, major operations, and cases where institutional treatment was necessary, such as pneumonia from the slums. The question of nationalisation did not, however, sink or fall with the degree of perfection of any one scheme. All thinking men must recognise the confused state of the medical profession, and agree that its co-ordination into a homogeneous whole was urgently to be desired.

Mr. E. P. POULTON opposed the motion. The nationalisation of the medical profession necessarily formed part of a general socialistic scheme. The medical service would have to be limited; this would cause serious difficulty. A competitive entrance examination would not indicate the men best suited for the profession, whilst elimination at the end of the course would be disastrous for the failures. A certain amount of socialist legislation was necessary, but the medical profession had no need of such reform. There was no lack of economy. All medical men had their hands full, and to them State service would make no real difference. Any bureaucratic arrangement would tend to limit free competition of worth. Some territorial arrangement would be necessary; this would be unfair to many patients. There would be constant friction between the general practitioner and consultant. The graduation of the medical tax would present considerable difficulty. At present the rich man, in paying £100 for his operation, paid for the poor man also, who was treated free of charge by the same surgeon at a hospital. The medical profession fared better than others; under a bureaucratic influence the practitioner would suffer even more than existing servants of the civil service. With regard to research, too much organisation was a great danger; the best research had been done by individual effort and in adverse circumstances.

Messrs. N. A. D. Sharpe and E. D. Scott ably seconded the motion and opposition respectively.

Messrs. Sandison, Ryle, Schlesinger, and Neft also made excellent speeches.

Dr. Spriggs pointed out that the profession had already been nationalised to a certain extent by its own representations. Education need not be regulated by the State, though entrance through one portal by a State qualifying examination was desirable; University degrees would then be regarded as academic distinctions, instead of qualifications merely for registration. Inspection of the poor was not so necessary as the organisation of labour; proper wages and temperance reform would go far to abolish many existing evils. For research, we did not require the foundation of numerous scholarships and fellowships so much as the institution of organised laboratories, with a capable head and workers to carry out his suggestions. This did not necessitate nationalisation, but it was essential that an adequate salary should be paid to the chief as well as to the actual researchers. The medical profession should adapt its course to the needs of the patients—and particularly the very poor—rather than to its own needs and aims.

The opposer and proposer having replied, the House divided, and the motion was carried by one vote.

Nursing News.

Miss E. M. Studdert left the Hospital on February 23rd to take up her new duties as Matron of the County Hospital, Hertford. Since completing her training, Miss Studdert had acted as Night Sister, Sister in Charge of Martha ward, and Hospital Housekeeper. Miss Florence Finnis (Sister Florence), who has been Night Sister since August last, was appointed Hospital Housekeeper; and Miss Hilda Edmonds, who completed her training in May, 1906, and who has held the appointment of Sister at the Children's Hospital, Birmingham, since October, 1908, has been appointed Probationary Surgical Night Sister.

On February 19th, Nurse Nelson, Head Nurse in Job ward, and Nurse M. Fraser, Head Nurse in Mary ward, left the Hospital on completion of their three years' training. Probationer Skinner was appointed Head Nurse in Job, and Nurse Barker Head Nurse in Mary ward.

On February 24th, Probationer G. Wallis was appointed Head Nurse in Bright ward.

On February 23rd, Nurse Quilter, Head Nurse in Cornelius, left the Hospital on completion of her three years' training, and Probationer Latcham was appointed to succeed her as Head Nurse.

On February 22nd, Nurse Whittam, Head Nurse in Martha, left the Hospital on completion of her three years' training, and Probationer F. Thompson was appointed to succeed her as Head Nurse.

On March 1st, Nurse Dudding, Head Nurse in Astley Cooper ward, left the Hospital on completion of her three years' training, and Probationer McAra was appointed to succeed her as Head Nurse.

On March 3rd, Nurse Bodenham, Head Nurse in Stephen ward, left the Hospital on completion of her three years' training, and Nurse Woollett was appointed to succeed her as Head Nurse.

On March 4th, Nurse D. Oliver, Head Nurse in Mary ward, left the Hospital on completion of her three years' training, and Probationer Rose was appointed to succeed her as Head Nurse.

On March 7th, Nurse Willcox, Head Nurse in Charity ward, left the Hospital on completion of her three years' training, and Probationer D. Carey was appointed to succeed her as Head Nurse.

On March 8th, Nurse Forsaith, Head Nurse in John ward, left the Hospital on completion of her three years' training, and Probationer K. Vine was appointed to succeed her as Head Nurse.

On March 9th, Nurse Kingzett, Head Nurse in Mary ward, left the Hospital on completion of her three years' training, and Probationer Lethbridge was appointed to succeed her as Head Nurse.

On March 17th, Nurse White, Head Nurse in Esther ward, left the Hospital on completion of her three years' training, and Probationer Norman was appointed to succeed her as Head Nurse.

Under the auspices of the Guy's Hospital Nurses Photographic Society, a Lantern Lecture was given in the Nurses' Home, on Wednesday, March 9th, on the British Antarctic Expedition. The slides were kindly lent by Sir Ernest Shackleton, M.V.O., and Mr. Frank Wild, one of the gallant little band of men who planted the Queen's flag "furthest South," was good enough to come and give a most graphic description of their travels and experiences, illustrated by the lantern on the screen. The large Recreation Room was well filled, and the nurses greatly appreciated the lecturer's account of the hardships endured and the bravery shown by the members of the expedition. At the close of the lecture, the Matron, in expressing the thanks of all present to Mr. Wild for his kindness in coming, said that, after listening to what had been told them, the difficulties met with at home seemed very small, and one should try and meet them in something of the same spirit with which the members of the British Antarctic Expedition encountered and overcame their great hardships.

The Sixth Annual Exhibition of the Nurses' Photographic Society will be held towards the end of next month, and it is hoped that there will be a great increase in the number of photographs sent in by members of the Nurses' League.

Reviews, etc.

Books for review should be addressed to The Editor, Gazette Office, Guy's Hospital, S.E. Their price should in every case be stated.

The Physiology of the Special Senses. By M. Greenwood, jr. (Arnold.) Price 8s. 6d. net.

This book is intended to supplement the accounts of the subject given in the ordinary text-books of physiology, and to form an intermediary between them and the original papers. The author assumes, we fear, a more extensive knowledge of mathematics on the part of his reader than is possessed by the average medical student, and his work would have been more readable if he had substituted a few good diagrams for the vast majority of his formulæ. For instance, line drawings, such as are given by Howell, would have greatly elucidated the descriptions of the course of the fibres of the nerves of taste, and of the structure of the organ of Corti.

Mr. Greenwood remarks that the statement that dichromatic vision "depends upon a visual system made up of two variables defined by such expressions as $A_1=F_1$ (x,y,z,) and $B_1=F_2$ (x,y,z) . . . is not free from objection." With this we entirely agree. But in the chapters on the Young-Helmholtz and Hering theories of colour-vision, the author frees himself from all this bombastic phraseology—which, after all, the reader can "cut"—and presents us with a really admirable account of the two hypotheses, their merits, demerits, and limitations. The suggestion that both are partly true, and that neither need be accepted to the exclusion of the other, is well-timed, and perfectly justified by the present state of our knowledge. Good work is done, too, in explaining away certain common mistakes relating to Helmholtz' terminology; thus, the retino-cerebral "fibres," corresponding with the three receptive substances, were originally meant as mere abstractions, convenient for purposes of thought, and not as having any concrete existence.

Several interesting chapters deal with the historical aspect of the subject, those on the eye and the ear being the best.

Tne account of cutaneous sensation, and of Head's personal experiments, is very full and up to date, but the following chapter, on Pain, is disappointing. Only five pages are devoted to it, and Dr. Head's eminently practical work on referred sensibility is dismissed with a brief notice. There is no mention of all the recent investigations on the sensibility of the viscera, and in this chapter one is particularly struck by the lack of reference to practical developments, which is apparent throughout the book. The whole subject of the physiology of the special senses is difficult enough, and much of it has no bearing upon subsequent clinical work; it is a pity not to vitalise it, whenever possible, by illustrations drawn from everyday medicine and pathology. Tabes and cerebellar ataxia are never mentioned, nor is Dr. Pembrey's famous hen.

The book is well printed, well bound, and not too long, and we recommend it to all who intend to enter for the higher examinations in physiology. The author has succeeded very well in amplifying the ordinary accounts of his subject without becoming too abstruse. The articles are about as "deep" as those in the familiar "Recent Advances."

The well-known firm of medical booksellers, Chas. J. Sawyer, Ltd., of 23, New Oxford Street, W.C., have sent us a copy of their latest catalogue of second-hand books dealing with medicine, surgery, and the allied sciences, which should be seen by anyone on the look-out for some special work, as it contains a large selection, and many of the books are offered at remarkably low prices. Works from the libraries of the late Dr. Radcliffe Crocker and the late Sir Thomas Stevenson are included in the list.

Periodicals Received.—The Hospital; The Clinical Journal; The Nursing Times; Manchester University Magazine; United Service Gazette; Le Mois Médical; Calcutta Medical Journal; St. George's Hospital Gazette; The Prescriber; London Hospital Gazette; St. Thomas's Hospital Gazette; St. Mary's Hospital Gazette; Polyclinic; Archives of the Roentgen Ray; St. Bartholomew's Hospital Journal; V.C.L. Union Magazine; British Health Review; Medical Missions at Home and Abroad; South African Medical Record.

THE EDITOR will, at all times, be glad to consider articles or sketches, provided that they are accompanied by the writer's name and address, not necessarily for publication. Payment is a matter of arrangement, and the fees that the Gazette *can offer are merely nominal, but if the writer desires any remuneration that fact should be stated. Authors who desire reprints of their papers should make their own arrangements with the printers when they return their proofs.*

Sport.

Rugby Football.

GUY'S v. ST. THOMAS'S.

INTER-HOSPITALS SEMI-FINAL.

Guy's put into the field for the first time a full side, Archer reappearing after his injury sustained a month ago against the United Services. It was a perfect afternoon on Thursday, March 3rd, for the above match. Just a little too warm, perhaps, for the players, but perfect for the good company of spectators who turned out to witness a thoroughly good sporting game.

Crook was a few minutes late, so the Guy's pack took the field one short. St. Thomas's went off with a great burst, evidently intent on drawing first blood, and thus gaining what is generally a valuable asset in these encounters. About ten minutes after the game commenced Medlock opened the scoring, with a good try, gained by individual work. Just previously Stokes looked like going over, but missed his pass from Lee. Stokes missed the conversion from Medlock's effort. Doubling inwards very cleverly after receiving from Jones, Lee crossed with the second try, Hind goaling, and thus making the score at half-time 8 to nil. Before ends were changed Thomas's had worked down very closely to Guy's line, where Stringer picked up, and swerving and diving right through the Thomas's men he got away to within about twelve yards of the Thomas's line, when Skeet tackled him; a magnificent effort, very different to a straight run. It was hard luck on Stringer that a score did not result. Jones gained a third try, unconverted, and then Welch put on 3 points for St. Thomas's, Meakin adding the extra two by converting. After this Guy's went ahead again, Stringer being the next try-getter. Afterwards Stranack and Medlock also went over the line. St. Thomas's, it should be stated, did not make much effort when Medlock scored, as one of their men was injured and required attention. The game was of course bound to proceed till the ball became "dead." Stringer's try only was converted by Hind, the total score being: Guy's, 2 goals 4 tries (22); St. Thomas's, 1 goal (5 points).

A word of praise should go to St. Thomas's pack, who played hard throughout, while Sparke, Skrimshire and Friedlander tackled for all they were worth. Team:—

GUY'S.—G. E. W. Lacey (back); L. B. Stringer, J. P. Jones, H. Lee, A. L. Stokes (three-quarters); C. H. Medlock, J. G. Saner (halves); H. Archer, G. R. Hind, W. E. Williams, A. H. Crook, C. S. L. Roberts, W. S. Stranack, R. S. Kennedy, A. V. Moberly (forwards).

Referee: Mr. E. F. Walker.

GUY'S v. LONDON.

FINAL TIE.

For this important and most interesting fixture, played at Richmond on Wednesday, March 9th, the most wretched weather prevailed, worse than any we can remember for a Final day. Throughout the afternoon the rain poured down continuously.

Just at first things looked very gloomy, but spirits rose as the milk can and its bodyguard arrived, and from then on there was plenty going forward to liven up the most depressed of spectators. Punctually to time, H.R.H. The Prince of Wales arrived, and the two captains, J. P. Jones and A. S. Heale, were presented. After they had descended from the Royal Box the teams filed out, and, after giving three lusty cheers for the Prince, faced each other.

Mr. A. O. Jones ably refereed, and very quickly the game commenced, with Guy's facing the entrance end, and getting the driving rain obliquely into their faces. Guy's started well; they forced the pace, and the forwards, who played magnificently throughout, set about their work with great determination. Above the storm, and between the lulls of the cheering, one could hear J. P. Jones' "Feet, Guy's, feet!" and feet it was with a vengeance. Several times Guy's were driven to midfield by touch-finders, but they worked back. Palmer's kick was charged down, Ash passed, and Archer dashed after the ball, but Adams reached it first. London replied, but their footwork was not so concerted, though their backs looked very dangerous, with Adams and Macpherson well away, but the ball was thrown forward before it reached Batchelor. Three times Stringer got possession, but he was marked in deadly style, and at last was knocked out by a bump on the head. After a little delay he resumed, but for a bit the steam was knocked out of him. At length, Guy's conceded a minor, and then the scene was changed. Roberts, who played grandly, led a rush to the other end. A scrum on the line, Palmer had carried over. A quick passing bout between Saner, Medlock, Lee, and Stokes saw the latter held on the line. Another scrum, and Saner sent out very smartly, Medlock accepted, and by a blind side swerve had scored a try. Deafening cheers went up, amid which Stokes made a good but unsuccessful effort to goal. Soon after, half-time was taken. Roberts, having gone lame, went off for a bit, but returned, still lame, just after the interval. He was very plucky to continue at all. As it was, Guy's were handicapped, for Roberts had been in brilliant form. Only a few minutes elapsed before Guy's were in again. Pressing London in the corner of their twenty-five, the forwards pushed their way over the line, the ball became loose, and Kennedy dived on to it. This time Hind goaled. For a little while Guy's appeared to slacken, and London were put into a good position by Adams making ground with a good run; he was tackled, but punted on, and Macpherson, fielding very cleanly, raced clear and round behind the bar. Adams kicked the goal, the ball hitting the upright and glancing over. London for a few minutes played like men possessed; Monteith, Morton, and Hodges led a terrific rush. But Guy's steadied themselves, and Jones and Lee working the touch-line, in which Medlock aided them very judiciously, drove them back. Batchelor managed to get off the

mark twice; Stokes, however, held him, and the really magnificent generalship of the Guy's captain did the rest. The forwards were as well together as ever; they pressed London back to their twenty-five, and here, by the splendid kicking of the backs, and the hard scrumming of the forwards, who never allowed the ball to become loose, they were kept till the long whistle went.

By 8 points (1 goal and 1 try) to 5 points (1 goal) Guy's had retained the Cup. Loud and long were the cheers, renewed again and again, as J. P. Jones mounted the steps of the Royal Box to receive from His Royal Highness the Cup and gracious congratulations.

Jones deserves them. He played a marvellous game. His touch-finding, fielding, his thought for his forwards, and his consummate judgment were splendid. This latter surely places him very high in the roll of Rugby captains. Teams:—

GUY'S.—G. E. W. Lacey (back); L. B. Stringer, J. P. Jones, H. Lee, A. L. Stokes (three-quarters); J. G. Saner, C. H. Medlock (halves); H. Archer, G. R. Hind, W. E. Williams, A. H. Crook, A. V. Moberly, C. S. L. Roberts, W. S. Stranack, R. S. Kennedy (forwards).

LONDON.—W. M. Ash (back); A. C. Palmer, D. G. Macpherson, A. A. Adams, T. B. Batchelor (three-quarters); A. S. Heale, A. B. Lindsay (halves); H. G. Monteith, C. M. Chapman, W. D. Kennedy, H. Whyte, H. J. Morton, W. C. Hodges, R. Morton, H. Dew (forwards).

REMARKS.—No one must be singled out for special mention; all were splendid. The forwards played right up to their reputation. Just before the game it became known that G. R. Hind had been "capped" for England against Scotland. Very sincerely is he to be congratulated; a hard honest forward, always in the heaviest of the work, has at length received reward, well merited indeed.

The majority of people present at Richmond had a thought in their minds for Mr. Mullins, a sympathetic and, as the afternoon closed, a very joyful thought, that the side for which he had done so much had been successful. The victory must have to some extent made up for his disappointment at his enforced absence.

GUY'S v. LENNOX.

This match was played under the pleasantest conditions at Wandsworth, on the Old Leysian ground, on Saturday, March 5th. The Final Cup Tie having been arranged for the following Wednesday, and in view of the hard matches the 1st XV. had recently played, it was thought advisable to give them all absolute rest. The 2nd XV., who have established a well-earned reputation as try-getters, therefore did duty, and right well did they act up to their reputation, winning eventually by 3 goals, 1 penalty goal, and 6 tries, to 1 goal; i.e., 36 points to 5. It is only fair to point out that Lennox were also rather below full strength. But this fact does not in any way detract from the very fine performance of the Hospital's 2nd XV.

Guy's kicked off, and worked away to Lennox's end of the field, and almost immediately set up a sustained attack. Pritchard was almost over, but Bull laid hold of him and prevented a try. But the opening score was soon forthcoming, Monaghan going over in the corner, after the forwards had made the pace very warm. Glendining could scarcely be expected to add to the points from the wide angle. Tries now came in quick succession, Pritchard, Danby, and Roe scoring in the order named, but only the last try was converted by Tweed. Monaghan next had a trial of strength along the touch line, and by sheer determination forced his way over very wide out. Glendining could do nothing with the kick, but just afterwards he dropped a wonderful penalty goal, practically from touch. Thus half-time arrived with Guy's leading by 20 clear points.

The second half was more even, as the Hospital lost the services of Tweed and Davies from the pack. Still, more tries were forthcoming, Roe, Harkness, Pritchard and Parry-Jones being the try-getters, Two of the efforts were converted. The goal by Lennox was the outcome of a combined effort on the part of their three-quarters, Lenney, a forward, joining in, and touching down for Bull to convert. Team:—

GUY'S.—H. Millett (back): A. S. Roe, W. T. Clarke, A. H. Harkness, — Davies (three-quarters); P. J. Monaghan (Capt.), C. B. Pritchard (halves); H. Hoby, H. R. Danby, A. W. Davies, J. Tweed, Parry-Jones, L. C. D. Irvine, V. Glendining, H. Gibb (forwards).

Association Football.

GUY'S HOSPITAL v. TOWNLEY PARK.

SEMI-FINAL SURREY COUNTY A.F.A. CUP.

This match was played at Weybridge, in delightful weather, and on a ground which, except for one corner, was in perfect condition. Winning the toss, Guy's chose to play with the sun, wind, and slight hill in their favour. Townley Park were the first to attack, and for some minutes the hospital defence looked in danger, but gradually they recovered themselves, and the ball was transferred to the forwards. Play was very fast and even; after twenty minutes, the score was opened for Townley Park by Bastard, who, in endeavouring to save a hard drive, only just touched the ball, which shot up into the net, giving Rook no chance to save. After this reverse the hospital forwards swarmed round their opponents' goal. From a pass from the left wing, Bergh neatly put the ball in the net, but the point was disallowed for offside. This seemed very hard luck, since the ball was within a yard of the back line before it was passed in. Nothing further in the way of scoring occurred in the first half, so Townley Park crossed over, leading 1–0.

On resuming, the hospital showed much improved form in the attacking division. A penalty against Townley Park for handling looked like levelling up the

score, but Birks' shot was saved by the goalkeeper. Shortly after, a good run by King, ending in a perfect centre, was slammed into the net by Humm running in from outside left. This was followed within a few minutes by a run on the left wing, initiated by Birks, and ending in Humm passing to Birks when in front of goal, and Birks scored with a fine cross shot. Again the hospital forwards attacked, and Bergh, assisted by Bevis and Birks, fairly beat the opposing backs, and scored. With the score now 3–1 in the hospital's favour, play declined slightly, but from a shot from Bergh the goalkeeper cleared badly, and Birks, running on, placed the ball in the net. With eight minutes to play, Holloway for Townley Park, scored with a perfect shot; and then, to the end of the game, a ding-dong struggle resulted in no further score. Thus the hospital won a hard game by 4–2, and have to play Weybridge in the final tie. Team:—

Guy's.—H. C. Rook (goal); H. Rowse Bastard, K. J. T. Keer (backs); P. V. G. Pedrick, J. Kyle, H. B. Neely (half-backs); R. M. King, S. Bevis, V. Bergh, A. H. Birks, P. S. Humm (forwards).

Remarks.—The team may be congratulated on this result, which, whilst being somewhat unexpected, was thoroughly deserved. Of the forwards, King, Bergh and Birks were in good form, especially King, whose centres were a feature of the game. Bevis was good, but still slow in tackling. All the halves were good, Kyle being very much improved. Bastard at back was a very important factor in the hospital victory, and seems to have settled down to his partner, Keer, quite comfortably. Rook in goal was good and safe.

GUY'S (Holders) v. KING'S.

Inter-Hospitals Association Cup.—1st Round.

Played on Wednesday, March 2nd, at Honor Oak Park, when Guy's, after scoring three times in the first ten minutes, won easily by 8 goals to nil. The game needs little description, the winners being superior in all departments, though King's played throughout with much pluck and energy. Birks, Jones and Bergh, the insides, divided the goals, three of which were scored in the first half and five in the second. Bevis gave a useful display at outside left, his first appearance there; Doll played well at right half, *vice* Crook; T. L. Jones came in for Humm, taking the centre forward position. Team:—

Guy's.—H. C. Rook (goal); H. R. Bastard and J. T. Keer (backs); W. H. Doll, J. Kyle and H. B. Neely (halves); R. M. King, V. E. D. Bergh, T. L. Jones, A. H. Birks and S. W. Bevis (forwards).

GUY'S v. St. THOMAS'S.

2nd Round.

Played on the St. Bart.'s ground on Friday, March 11th. This was a much better game, being fast and vigorous all through; Guy's, however, were the cleverer side, and staying better than their opponents, won by 5 goals to 1. Guy's quickly settled down and forced a corner, which was beautifully taken by King and headed through by Jones (1—0). Ten minutes later Birks ran through and with a neat shot put Guy's two up. After this St. Thomas's found their form, both wings being prominent; Bastard and Keer were equal to them, and the game proceeded fast and even till half-time, no further scoring taking place till then.

On resuming, a fine centre by Bevis went begging, and Birks put in a characteristic run and sent across to Bergh, who easily found the net. Thomas's were often dangerous, but their efforts lacked finish. Walker, however, put in one hot shot which beat Rook (3—1). From this point to the end Guy's had most of the game and pressed continually. A neat through pass by Neely to Bergh enabled the latter to score a fourth point for Guy's, and shortly afterwards Neely sent in a long shot which hit the cross-bar and came to Bergh, who performed the hat trick and made the final score 5—1 in favour of Guy's. Team:—

Guy's.—H. C. Rook (goal); H. R. Bastard and J. T. Keer (backs); J. Kyle, A. H. Crook and H. B. Neely (half-backs); R. M. King, V. E. D. Bergh, T. L. Jones, A. H. Birks and S. W. Bevis (forwards).

Remarks.—Rook saved finely on several occasions. Keer was at his best and kicked well. Bastard played his usual highly-polished and effective game. Crook was ubiquitous and always had the measure of his insides. Both he and Neely used their heads well; the latter was a little wild but did good work. Birks was in great form all through; Bergh was only himself in the second half, when he scored three good goals. Jones was always bustling and doing useful work, but the outsides did not have much of the game, though both made good use of their opportunities, especially King.

Summary of 1st Round.—Guy's beat King's, 8—0; St. Bart.'s beat University, 8—1; London beat Middlesex; St. Thomas's beat St. Mary's.

2nd Round.—Guy's beat St. Thomas's; St. Bart.'s beat London.

Final.—Guy's (holders) v. St. Bart.'s. Tues., March 22nd, at Hale End (London Hospital Ground).

GUY'S HOSPITAL v. REIGATE PRIORY.

Re-played Semi-Final.

(International Trophy du Nord.)

This match was played at Honor Oak Park on Saturday, March 5th, under ideal conditions. The ground was dry but very lumpy, owing to a match having been played on the previous Wednesday, when the ground was very heavy. As Guy's had previously beaten Reigate in the Surrey Cup, and drawn at Reigate in the first match of this trophy, it was hoped that they would win again; but though far superior in the mid-field play, the Hospital forwards failed miserably in

their attempts to score. From the kick-off Guy's attacked vigorously, and should have opened the scoring through Humm at close range, but owing to his not gathering the ball at the right moment, the chance was lost. Then Reigate attacked and scored, whilst the Hospital defences were appealing for an apparent off-side. The goal was allowed, so the Hospital tried hard to level scores. Bergh failed to score with no one but the goal-keeper in front of him, and half-time arrived with Reigate leading 1–0.

On resuming, the Hospital set up a continual attack, but with no result until twenty minutes from time, when Jones headed a beautiful goal from King's centre. Another goal was disallowed for Jones charging the goal-keeper just beforehand. From the kick-off Reigate attacked, and for some reason or other the Hospital defence seemed to stand aside, whilst Reigate deliberately put the ball into the net. It is difficult to realise a more ridiculous bit of indifference than that shown in this particular part of the game. From here to the end of the game Guy's were in front of the Reigate goal, with innumerable chances of scoring, but with no goals scored, and when the whistle blew Reigate were leading by 2 goals to 1. Team :—

Guy's.—H. C. Rook (goal); H. R. Bastard, K. J. T. Keer (backs); P. V. G. Pedrick, J. Kyle, H. B. Neely (halves); R. M. King, S. Bevis, V. Bergh, T. L. Jones, P. S. Humm (forwards).

Remarks.—The result was due primarily to the ineffectiveness of the Hospital forwards. A win of 5–0 should have been recorded with fair ease, despite the excellence of the Reigate goal-keeper. King was good, but the rest, whilst being excellent in mid-field, were useless in front of goal. All in the defence played well, and except for allowing the second goal to be scored, there was no fault to be found with them. It is to be hoped that against Weybridge next Saturday, March 19th, the forwards will have their shooting boots on.

GUY'S 2nd XI. v. LONDON 2nd XI.

Inter-Hospital Junior Cup Tie. Semi-Final.

Played on London's ground, on March 16th. Guy's won the toss, and playing with a strong sun at their backs and a slight advantage in a fairly strong cross wind, soon crossed London's line and gave the goal-keeper some anxious moments. London soon retaliated, but did not succeed in getting very close to goal, though Rhys-Evans had to handle once or twice. Guy's now attacked in spirited fashion, and after several shots had been sent in, scored their first goal, Wain easily beating the goalkeeper with a good shot. The same player a few minutes later sent in a stinging shot which hit the upright. Half-time arrived with the score. Guys, 1; London, 0.

In the second half Guy's had quite as much of the play, but owing to the indifferent shooting of the forwards did not succeed in increasing the lead until about a quarter of an hour from the end, when Matthews beat the goalkeeper at close quarters. London on several occasions made dangerous rushes towards Guy's goal, but did not succeed in scoring, and the whistle blew for time with the score: Guy's, 2; London, 0. Team :—

Guy's.—J. E. Rhys-Evans (goal); C. D. Neal, C. E. Rice (backs); V. F. Golledge, J. A. Edmond, E. L. Jones (half-backs); A. F. Camp, D. Wain, W. Matthews, G. W. King, C. G. McClymont (forwards).

Remarks.—There was not the usual cup-tie excitement and bustle about this game. The play of the forwards in midfield was better than usual, but their shooting was not at all of the type to win cup ties. Camp, on the wing, played a particularly good game. The defence was never much bustled, and Rhys-Evans, in goal, was able to get well away any shots that were sent in.

Hockey.

GUY'S v. ST. THOMAS'S.

1st Round Inter-Hospital Competition.

This match was played on the Brondesbury ground on February 9th, and resulted in a fairly easy victory for Guy's. The ground had suffered from recent rains, and hence accurate play was difficult. Despite this fact, our forwards showed up to great advantage, Poulton, Bromley, and Camp frequently being conspicuous by their excellent combination. The opposing forward line were not strong, though Gardner was at times dangerous, and would have been more so if he had been well backed up. Their defence was fair, Wainwright displaying much energy, but the combination of our forwards was too much for them. The goals were scored by Poulton (4), Bromley (2), and Camp (1) the final score being 7 goals to 3. Early in the game Archer had to retire into goal, owing to injuries, but Pern filled the vacancy with considerable success. Team :—

Guy's.—M. Pern, H. L. Duke, H. Archer, W. T. Clarke, F. Kahlenberg, G. T. Thomson, F. A. Dick, L. Bromley, E. P. Poulton, F. Camp, A. H. Birks.

GUY'S v. BART.'S.

2nd Round,

This Cup Tie was played at Richmond on February 21st. The ground was in excellent condition, thus rendering the play somewhat fast. Archer was unable to turn out, so Pern filled the vacancy and Morres kept goal. During the first half our forwards combined well, but had few opportunities of scoring, owing to the sound defence against them; however, they managed to make the most of their opportunities, and scored 2 goals. Bart.'s made several attacks on our goal, but could not score, their forwards being decidedly weak at shooting.

In the second half our forwards were excellent, Poulton being in great form, and his shooting admirable. Bromley and Camp rendered him useful assistance, and Birks on the wing was good. Clarke and Duke played a strenuous game; and Morres was very safe in goal. The final score was 7 goals to nil, Poulton 5, Bromley 1, and Camp 1, scoring the goals. By winning this match, we meet London in the final. Team:—

GUY'S.—F. Morres, H. L. Duke, M. Pern, G. T. Thomson, F. Kahlenberg, W. T. Clarke, A. H. Birks, F. Camp, E. P. Poulton, L. Bromley, F. A. Dick.

From the Gazette's Special Pathologist.

ALL specimens—particularly those of solid tissues—should be accompanied, if possible, by a short clinical and post-mortem history, and a postal order for 2s. 6d. An extra charge of 6d. per slide is made when prepared sections are to be forwarded.

Directions to be followed in sending *Diphtheritic Membrane*;—Remove as much of the membraneous exudation as possible with a pair of forceps, which have been sterilized by boiling water. Place the exudation in a small, perfectly clean empty bottle, with a well-fitting glass stopper, and forward without delay. No preservative fluid should be used. The specimen must be accompanied by a Postal Order for 5s. A telegram will be despatched immediately the examination of the specimen is completed.

Diphtheria specimens are to be labelled *Immediate*.

Specimens, Letters, and Postal Orders should be addressed to the MANAGER, Gazette Office, Guy's Hospital.

NOTICE.

J.C., MARKET HARBOROUGH.—This is not a new growth, but an inflammatory lesion involving connective tissue and striated muscle. It contains large areas of inflammatory leucocytes, especially around the vessels in the fibrous tissue and muscle. We find no caseation and no evidence of tubercle, and conclude that it must be the result of some infection.

PATHOLOGIST.

Papers by Guy's Men.

A. Ernest Maylard, M.B., B.S. Lond.: An Address on Reflex Pain in Diseases of the Abdominal Viscera. (Illustrated.)—*British Medical Journal*, 12th March, 1910.

R. P. Rowlands, M.S. Lond., F.R.C.S. Eng.: A Clinical Lecture on How to Operate for Appendicitis.—*Ibid.*

Geo. Steele-Perkins, M.D. Edin., M.R.C.S. Eng., L.R.C.P. Lond.: A Case of Rheumatoid Arthritis Treated by Thyroid Extract.—*The Lancet*, 5th March, 1910.

J. Ashburton Thompson, M.D. Brux., D.P.H. Camb.: On a Trial of Nastin.—*British Medical Journal*, 5th March, 1910.

Change of Address.

P. J. Kolaporewalla, M.R.C.S., L.R.C.P., from Guy's Hospital to the Free Eye Hospital, Southampton.

A. Norman Leeming, M.B., B.S. Lond, M.R.C.S. Eng., L.R.C.P. Lond., from Guy's Hospital, to Wernett House, Station Road, Old Colwyn, North Wales.

E. Laurence Pilbeam, L.D.S., from 15, Lansdown, Stroud, Glos., to the Royal Naval Barracks, Shotley, Suffolk.

(The Editor will be very glad to receive a postcard with notes of any change of address.)

Notice.

Operative Surgery.

Advanced Course of Operative Surgery, adapted to the requirements of Students presenting themselves for the Final Examination in Surgery at the Universities, and for the Diploma of Fellow of the Royal College of Surgeons. (Mr. Rowlands.)

Special Classes in Operative Surgery and Surgical Pathology will be held as follows:—Operative Surgery, Mondays at 2.30 p.m.; Thursdays at 10.30 a.m. Surgical Pathology, Mondays at 1.30 p.m.; Tuesdays at 1.30 p.m. First Class, Monday, 21st March, 1910.

The Classes in Surgical Pathology are open to all Students of the Hospital.

Fee for the course, five guineas.

Deaths.

EYRE.—On Sunday, March 6th, Leslie Graham, aged three months, the youngest son of Dr. and Mrs. John Eyre.

RICHARDSON.—On January 15th, at Toronto, James Henry Richardson, M.D. Toronto, M.R.C.S. Eng., late Professor of Anatomy in the University of Toronto, aged 87 years.

ED.—A. N. C.

GUY'S HOSPITAL GAZETTE.

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Calendar of Coming Events and Ensuing Take-in Weeks.

April.

Sat. 2. Guy's XV. v. Catford Bridge (Kent County R.F.U. Challenge Cup), Rectory Field, Blackheath.

Tues. 5. Final Conjoint Examination begins.

Thur. 7. Messrs. Dunn and Rowlands' Take-in (Messrs. Lucey and Francis).

Fri. 8. May Appointment List closed.

Thur. 14. Sir Alfred Fripp and Mr. Turner's Take-in (Messrs. Brown and Elliott).

Passim.

THE Annual Meeting of the British Medical Association is to be held in London this year, from the 22nd to the 29th of July, at the University of London Buildings in the Imperial Institute. A number of Guy's men are taking part in the proceedings in various capacities. Dr. Lauriston E. Shaw is one of the three honorary local secretaries; Mr. Higgens is President of the section for Ophthalmology; Mr. Rowell a Vice-President in the section for Anæsthetics; Dr. Eyre a Vice-President in the section for Bacteriology; and Mr. Steward a Vice-President in the section for Diseases of Children. The following are honorary secretaries in the various sections mentioned:— Dr. French (Medicine), Dr. G. Norman Meachen (Dermatology), Mr. E B. Dowsett (Odontology), Dr. A. E. Boycott (Pathology), and Dr. A. F. Hertz (Pharmacology and Therapeutics).

ONE of the two subjects selected for discussion by the Surgical section at these annual meetings is "The Principles which should govern the Operative Treatment of Simple Fractures." In this connection we may mention that an excellent article on "Le Traitement Chirurgical des fractures diaphysaires fermées," by Dr. R. de Boris, Professor in the Reims School of Medicine, appeared in *La Semaine Médicale* for February 16th. The writer gives a very complete account of the history, technique, and results of the operative treatment of fractures, and pays a handsome tribute to the work of Mr. Arbuthnot Lane in this department of surgery.

THE final meeting of the Physical Society for the present season was held on March 18th. Dr. Hale White announced that he had selected for the Treasurer's Prize the essay bearing the motto "Icarus," which was found to belong to Mr. Frank Cook. The first part of this essay, "On the Ætiology and Pathology of Pigmentation in Constitutional Disease," is published in the present issue of the GAZETTE. It was

announced that the Society's Prize for the best paper read during the session had been awarded to Mr. Mutch for his paper on "Appendicitis," and that for the best specimens shown to Mr. James. The prize for the best speaking in the discussions was again, as in the last few years, we believe, not awarded. The following members were elected Presidents of the Society: Messrs. Bromley, Catto, Marshall, Mullally, Mutch, Poulton, Sandison, and J. G. Saner.

In view of the approach of the Biennial Dinner, the account of a hospital dinner nearly ninety years ago, which will be found on another page of this issue, is of interest. This account is abstracted from the *Lancet* of that period; it will be seen that the proceedings were somewhat Bacchanalian, and we can scarcely promise such an orgie for the hospital dinner this July. Nevertheless, in its more sober, modern way, it will doubtless be a very enjoyable function.

We are glad to hear that a number of Mr. Wingent's clever drawings of hospital subjects are to be republished in volume form. Many of these have appeared as supplements to the Gazette; others have formed frontispieces to various programmes of theatricals, concerts and other hospital functions, but in any of these forms they are likely to be lost or damaged, and many old Guy's men and nurses will no doubt be glad to possess them in the more artistic and permanent form of a booklet. Those especially who have taken part in concerts and theatricals in the past will be glad to renew their acquaintance with the drawings which Mr. Wingent always so generously executed for programme covers.

Under the auspices of the Guy's Hospital Nurses' League, a course of six post-graduate lectures for nurses has been arranged, to commence on Tuesday, April 5th, in the Nurses' Room, at 8 p.m. The lectures will be given by Dr. H. C. Cameron and Mr. E. C. Hughes, and their subject—"Recent Changes and Treatment in the Medical Ward, The Mental Factor in Disease, Recent Surgery, and the After-Treatment of Abdominal Operations." The lectures will be printed in pamphlet form, and sent post free to all subscribers. The fee for the course will be: Members, 5s.; non-members, 7s. 6d. Intending subscribers should send in their names to the Matron as soon as possible.

The Residents' Going-off Dinner was held last Wednesday, on the eve of their dance. Mr. H. R. Mullins, who is getting on famously without his appendix, and has now happily quite recovered from the loss of it, was elected the new President, and Mr. H. C. Lucey the new Vice-President.

It is always a matter of interest to the writer of these columns to find that his brethren of the other hospital gazettes have their doubts and difficulties to contend with also. Thus, in the current number of our excellent contemporary, the *Middlesex Hospital Journal*, we find a confession that the "Editorial staff feel that the Journal is too solemn." On the other hand, the Editor of *St. Mary's Hospital Gazette* opens his monthly notes, which are quite the reverse of solemn, with the remark: "The complaint often reaches us that there is no news in the Gazette," and he goes on to say: "Readers of the Gazette may be classified under two headings: (1) Those demanding a small *Lancet*; (2) those who ask only for news and an odd laugh. An illustrious representative of the former class assured us at the dawn of our editorial life that he had no use for a weak *Pink 'Un*, which is, we understand, a periodical in which the medical references are not always in the best taste. The second class is even more definite in the expression of its demands and desires."

Both these complaints, of undue solemnity and of lack of news, have at various times been levelled at our own heads, and no doubt with considerable justification. It is at once an advantage and a drawback that a hospital paper should be both serious and frivolous; an advantage in that almost any kind of contribution may be considered, and a drawback in that the serious person is deterred from sending his serious copy to a journal in which he finds frivolous matter given a place. Worse still is

the plight of the poor editor when the serious copy which is sent to him is too funny, and the funny stuff too solemn, to print.

But gaiety and gloom, mixed in varying proportions, are characteristic of hospitals, as well as of life in general, so that the hospital Gazettes are faithful mirrors of truth, more faithful than your *Pink 'Un*, on the one hand, or your *B.M.J.*, on the other. To contributors, then, we would say: Send your contributions, whether serious or frivolous, for we have readers for both sorts of article.

Yesterday the section of the Midwives Act, 1902, which prohibits the practice, "habitually and for gain," of uncertified women, except under medical supervision, or in cases of emergency, came into force, and another nail has thus been driven into the coffin of Mrs. Gamp. Nevertheless, in districts such as the Borough, she will probably die out very slowly. The report of the Departmental Committee, which was appointed to consider the working of the Act, contains a suggestive paragraph on this subject:—"The difficulty of replacing the unqualified woman by a superior order of practitioner is not unfortunately altogether a question of supply, as, apart from the feeling of medical men in the matter, the reluctance of a certain class of the poor themselves has to be overcome; we were told that in many cases they prefer the old type of attendant, who is probably well known to them and is usually more helpful in the house, although she is often uncleanly and inexpert. Sometimes, too, the preference may be due to her companionable, not to say convivial, qualities, and occasionally, but we hope rarely, to the more sinister reason, as a medical officer put it, that she is believed to enjoy 'a lot of churchyard luck.'"

Periodicals Received.—The Hospital; The Clinical Journal; Charing Cross Hospital Gazette; Middlesex Hospital Journal; St. Mary's Hospital Gazette; The Nursing Times; Manchester Medical Students' Gazette; The Calcutta Medical Journal; The Stethoscope; New York State Journal of Medicine; South African Medical Record.

Lacerated Wound of Knee-Joint.

In adding the later note of the case forming the subject of the clinical lecture in the last issue, I omitted to refer to the treatment by vaccines. Mr. Crook has summarised the notes, and adds his opinion that the vaccines did much for the boy, an opinion shared by Mr. McNair, dresser to the case. A pure growth of streptococcus longus was isolated by Dr. Eyre, and the first injection was given on February 24th, just twenty-three days after admission. The temperature at night ranged between 101·5° and 102·5°, and the pulse 120. In the morning the temperature was nearly normal. No marked effect was observable; indeed, the temperature, which had begun to fall, rose again, and the boy seemed rather the worse. After consultation with Dr. Eyre, we agreed to give another dose of vaccine. This was given on the 28th, four days after the first. The temperature fell to an average of 100·5°, and the boy looked better and brighter. The vaccine was repeated on March 4th, 9th and 15th, by which date the boy was mending rapidly. It may be added that on March 26th he was about on a wheeled couch, had regained his colour, and could be moved without pain.

That the employment of vaccines was synchronous with his improvement there can be no doubt. It is more difficult to ascribe the improvement to their effect. The boy was even worse after the first dose, and when the second was given he was still stationary. It must also be noted that the surgical treatment was continued, and that the vaccines were not begun till the end of the third week, by which time the boy was beginning to mend in a general way. That is to say, he played with other children, and was comfortable, and slept well. However, I am free to admit that his progress was much more rapid after February 28th than one usually sees, and there can be no doubt that he is freer from pain at the present time and showing more rapid consolidation than usual. This difference must, I think, be set down to the effect of the vaccines.

C. J. S.

"A City Practice."

A Sketch.

In the private saloon of a hostelry off Cheapside half a dozen men were hobnobbing together over sundry drinks. A keen, sharp, Yankee-looking person seemed to be instructing his companions.

"Now then, Peter," said he to a jovial-looking man with a red face and a redder nose, "you are suffering from chronic dyspepsia, and like to drop in about once a week to be fixed up after a banquet in the City. Your fee is a guinea—here it is—and mind you fork it up *in toto*." To a second man, sallow of complexion, he shot forth thus: "Bill Rayner, remember both your parents died of a wasting disease, and you can't get it off your mind as you sit in your counting-house in Mincing Lane. Tell him that Dr. Robinson has been a comfort to you for the last year or so, and that his fee of half-a-guinea—here it is—is money well spent whenever you feel low, which you so constantly do, see?" He next addressed a small man with a bald head. "Mr. Johnson, how long is it that you have been bald?" "All my life, I believe," replied Johnson taking a pull at a tankard. "Nothing of the sort," said Dr. Robinson with emphasis, "a steady loss of hair—weak follicles you're told, that want looking at every week thro' a magnifying glass, and reporting upon to your wife, eh?" A general laugh arose from the little company as Johnson took the half-a-guinea to pay the doctor's fee. But the sharp man continued, "Mervyn Meredith, you know what's the matter with you, eh?" "Yes," he sighed, "I'm sorry to say I'm quite a genuine case. I'll be seven and six, please." Again the doctor forked out the fee. Then he spoke to the last man, one named Curling, whom he called an asthmatic, and otherwise abused him. To each and all he gave instructions to go to the consulting rooms the following day, and consult the doctor who was negotiating for the practice. Every man was to pay his fee down, and to fix another consultation for the following week. "Gas it, boys, and do the genial; talk of your friends who come there, too; and don't you forget, Peter, to speak of that bit of shootin in Norfolk, where you invite your friend Dr. Robinson when he's exhausted after the season's practice. Now then, boys, drinks round once more, and meet me to-morrow afternoon at five thirty in this blooming bar, and we'll settle up accounts."

* * *

The next evening Dr. Robinson met Dr. Verisopht-Blighter at the latter's lodgings in Pimlico. The pale-faced gold medallist and prize-winner was in a pleasant mood. "Dirt cheap," he had muttered to himself more than once since the morning's trial in the City, with its collection of three pounds ten shillings and sixpence in fees from the five "chronics," whom he hoped to count as old friends in the future. Downstairs in the sitting-room he cheerfully counted out the bank-notes for £200 as the price of the City practice.

"Oh, I quite agree," he said, "that books are useless in these consulting practices. They can be manipulated; they mean nothing. No, Dr. Robinson, one day's work like this morning's has shown me what the practice really is. Good patients, and good fees paid in cash—that is what I call a good practice. You hop out and I hop in without any talk about it. Professionally I have even the pull of you, inasmuch as I have a double name. I consider your advertisement spoke truth, Dr. Robinson; it is indeed a bargain for a bachelor. I wish you success in the Colonies, and I hope your health will soon be restored."

* * *

It is a month since Dr. Blighter bought the City practice, and he sits daily in his consulting room from eleven to three. Except for a few chemists' travellers, not a soul has crossed the threshold since the "trial day," with its flourish of patients and fees. Dr. Blighter is wondering where the patients have gone to; and the horrible thought is taking possession of his mind that City people have discovered that he is a gold medallist and a prize-winner, and have been frightened away from so scientific a man. Anyway he is profoundly dissatisfied.

FREDERIC VICARS.

One-Sided Conversations.

II.—A Case for Diagnosis.

Good-morning, doctor. . . . Bloomin' ill, or I shouldn't be in 'ere, I can tell you. . . . That's just what I want *you* to find out. . . . Oh! pains in my inside. . . . John Smith, . . . 43 a week come next Tuesday. . . . My *what*? . . . Oh, what's my work? I'm married. . . . 21, Love Lane, Ladysmith Street, Rotherhithe. . . . I've been married this five or six years. . . . Yes; she's very well considerin', except for a cold in the 'ed. . . . My mother's dead, but father's still alive. . . . Yes, she died in Miriam's Ward with a bleeding hæmorrhage. . . . My father was once an out-patient under Dr. Beddard, and he's never been the same man since. . . . I don't know what it was, nor did 'e, but 'e used to dror on 'is chest with a blue pencil. . . . Yes; I've got five. . . . They're all quite well, but really, young fellow, you seem to be mighty interested in my family. . . . Me? yes; I was in St. Stephen Ward under Dr. Pitt five years ago last Derby Day. . . . 'e called it 'edache and infernal strapismus, I think; you see I'd been riding a lot on them electric railways, but the sister, she said it wer'n't nothing of the sort! . . . Yes; it got quite alright, they used to take drops of blood out of my ear, and that soon cured me. . . . I was in Cornelius Ward once, with a broken tooth; Dr. Lane, 'e put a plate on it for me. . . . when did it start? Oh, about six weeks ago. . . . It's a kind of a drawin' up pain that catches me just 'ere. . . . Did I *what*? . . . Oh, yes, I was sick every day. . . . well, nearly every day. . . . about once a week, I think. . . . Let me see, once . . . er, twice. . . . yes, I've been sick twice . . . About six months ago. . . . Well, it mostly comes on after my dinner. . . . Sometimes at once, sometimes a little later. . . . No, I don't know nothing what'll stop it excepting a drink or two. . . . Yes, I 'ave a drop of beer now and again. . . . About eighteen 'arf-pints, sometimes more, sometimes less, but nothing what you would call excessive. . . . No; I never 'ad it before, and I don't want it again, I tell you. . . . *ninety-nine*. . . . *ninety-nine*. . . . (and the usual etceteras).

Probable diagnoses by the staff:—

Dr. H— W—	...	Diagnosis deferred.
Dr. P—t	...	Tumour of mid-brain involving, &c., &c., &c., &c.
Sir C— P—	...	Scabies.
Dr. S—w	...	Febricula.
Mr. L—e	...	Chronic intestinal stasis.
Dr. F—tt	...	Abdominal pain and history of vomiting.
Dr. F—h	...	High specific gravity urine.
Dr. B—d	...	Bunkum.
Dr. H—z	...	Pre-ulcerative duodenitis.

A. NUTT.

Appointments.

Medical School Appointments.

The following appointments have been made by the Treasurer upon the recommendation of the Medical Council:—

Clinical Assistants.—Messrs. F. S. D. Berry, F. Kahlenberg, G. H. Peall, A. E. Rayner, F. D. Saner, J. G. Saner.

Clinical Assistants in Medical Out-patients.—Messrs. L. Mandel (Drs. Fawcett and French); W. T. Clarke (Drs. Beddard and Hertz).

Dressers in the Throat Department.—Messrs. A. Neville Cox, H. Gardiner, G. H. Hunt, W. S. Kidd, R. Stout, C. C. Tudge.

Medical Ward Clerks.—(Extensions.)—Messrs. T. B. Heaton, E. G. Schlesinger, P. Smith, H. N. Eccles, C. A. R. Gatley (Dr. Hale White); J. L. Stewart, Jap Ah Chit, W. J. D. Smyth, L. M. J. Menage (Dr. Pitt); F. Cook, V. Glendining, F. N. Doubleday, H. L. Hopkins, C. Aldis (Sir C. Perry); A. C. L. d'Arifat, S. S. Crosse, V. A. Luna, C. F. Constant, G. B. H. Jones (Dr. Shaw). J. P. Jones, F. C. Hunôt, E. C. Cline, A. Tilbury, H. C. Godding, E. L. Jones, F. Tooth.

Assistant Surgeons' Dressers.—Messrs. T. P. Cole, H. Sharpe, M. Pern (Mr. Steward); E. C. Peers, F. C. Newman, V. F. Soothill (Mr. Fagge); W. S. George, G. W. B. Garrett, D. A. Davies (Mr. Rowlands); C. Worster-Drought, C. Warner, R. S. Kennedy (Mr. Turner).

Surgical Ward Clerks.—Messrs. G. W. King, K. B. Clarke, H. J. Hoby, T. Hampson.

Post-mortem Clerks.—Messrs. H. W. Barber, E. Billing, A. D. Vazquez (April 1st); N. Mutch, A. H. Todd, A. J. McNair, C. D. Killpack, H. L. S. Griffiths, H. H. Davis (May 16th).

Clerks in the Skin Department.—Messrs. F. Cook, V. Glendining.

Aural Surgeon's Dressers.—Messrs. R. Stout, H. V. Leigh, W. T. Clarke.

Obstetric Dressers.—Messrs. J. M. Jarvie, G. T. Mullally, G. R. Hind, J. H. Campain, F. S. Adams, H. L. Attwater (Mr. Targett); F. A. Dick, A. M. Bodkin, T. S. Sharpley, A. H. Gool, G. A. Blake (Mr. G. B. Smith).

Clerk in Electrical Department.—Mr. B. Blackwood.

St. Thomas's and Guy's Hospitals.

Anniversary Dinner, 1824.

From The Lancet, *January 11th, 1824.*

On Thursday last, January 8th, the practitioners who have been educated at St. Thomas's and Guy's Hospitals, and the gentlemen now attending those institutions, dined together at the Freemasons' Tavern. Mr. Travers presided, and was supported on his right hand by Sir Astley Cooper, and on the left by Dr. Cholmeley. At seven o'clock, about 150 gentlemen sat down to an excellent dinner. Most of the distinguished members of the Profession connected with these institutions were present. . . . . As soon as the cloth was removed, Messrs. Broadhurst, Leete, Terrail, Fitzwilliam, &c., sang the grace of the Wyckamists. The solo, "Sit nomen tuum, Domine, benedictum," was given in a very effective manner by Master Smith.

The Chairman gave "The King," with three times three, which was drunk with enthusiasm—Air, "God Save the King."

The Chairman next gave "The Duke of York and the Army"—Glee, "How Merrily we Live that Soldiers be."

The Chairman gave "The Duke of Clarence and the Navy"—Air, "Rule Britannia."

The Chairman said the next toast he should give was comprised in two words, to the point of which no observations of his could add any force—he meant "Old England." The toast was drunk with applause—Glee, "Here's a Health to Old England."

The Chairman, in proposing the next toast, spoke to the following effect:—I believe, gentlemen, you will agree with me, that there is no country in Europe—I might say, in the world—in which the medical profession is held in higher estimation than in our own. Many reasons might be assigned for this circumstance; and I will, with your permission, mention two or three. The first is, that the means of medical education are provided for by institutions like those which we are this day met to celebrate; and that this education is required or exacted by other institutions, namely, the chartered or incorporated bodies which compel an examination in the several branches of medicine, surgery and pharmacy. Another and a very important reason is, that education cannot be had for nothing in this country; and that the education required for our profession is both elaborate and expensive. These circumstances determine persons, who have a certain stake in the country, with respect to property and respectability, to bring up their sons to the medical profession. Another circumstance contributing to the high character of the profession in this country is its union with science. In proportion as the medical art has become more intimately connected with scientific pursuits, and as its improvement has been commensurate with the advancement of science, a high degree of education has become necessary, and every member of our profession, in all its branches, is inspired with a degree of enthusiasm which, in no profession, has been more intensely felt, or more universally diffused.

Another circumstance is, the more than ordinary share of eminent men who have contributed in this country to shed a lustre on their profession. I need not remind you of the names of Harvey, Sydenham, Cheselden, and, in more modern times, the Hunters, Sharpe, Pott, the late Dr. Fordyce, and the still later, and ever to be lamented, Dr. Baillie. . . . Having made these few observations, gentlemen, I beg leave to propose "Success to the scientific cultivation of Medicine and Surgery all over the world." The toast was drunk with applause.

The Chairman next gave "The Royal College of Physicians."

Dr. Cholmeley replied.

The Chairman next gave "The Royal College of Surgeons."

Sir Astley Cooper returned thanks for the honour which had just been conferred on the body of which he was a member. I join most cordially, said Sir Astley, in the wish for its prosperity, and I hope and trust that the College will continue to deserve well of their country by opening their museum to the public with the same liberality which they have hitherto displayed, by continuing a course of lectures, which cannot fail to be highly useful to all the practitioners settled in London, and by a careful and strict examination of the gentlemen who appear before them. I can myself bear testimony to the ability and diligence of many of the gentlemen who are preparing themselves most admirably for their profession by the study of its different branches, and especially by the study of anatomy, which can alone lay a solid foundation for their future prosperity and enable them to practise their profession scientifically and well. Gentlemen, I beg leave to drink all your healths. (Loud applause.)

The Chairman next gave "The Worshipful Company of Apothecaries."

Mr. Gaitskell rose to return thanks.

The Chairman said that the specific object of their meeting on that day was undoubtedly to commemorate the institution of the hospitals of St. Thomas and Guy. They had, however, another and a higher motive, which was the general advancement of medical science. He hoped, therefore, it would not be considered inconsistent if, before he gave St. Thomas's and Guy's Hospitals, he proposed "Prosperity to the Metropolitan and Provincial Hospitals." The toast was drunk with applause.

Master Smith sang, "We're a' noddin'," with much sweetness, and was loudly applauded.

The Chairman then proposed "St. Thomas's and Guy's Hospitals." The toast was drunk with enthusiastic applause.

Mr. Fitzwilliam sang a medico-comic song, which was vehemently applauded. A stanza, alluding to the scarcity of subjects in the following facetious vein,

Though Subjects be so scarce,
I'd scarce be one myself, sir,
Tol de rol, de rol,

appeared to give particular satisfaction. It was rapturously encored, as they say in the play-bills.

The Chairman,—Although we are honoured with the company of the Senior Physician of Guy's Hospital, I regret to state that the physicians of St. Thomas's Hospital are not present. It is my duty, gentlemen, as Chairman, to state to you that the absence of those gentlemen arises from no want of courtesy to the individuals assembled. Neither does it arise from want of invitation on the part of the stewards. The reason which they allege, gentlemen, is, that they do not participate in the business of teaching. On this point I must say that I differ from them; because, in the practice of the hospital, which forms an essential part of the business of teaching, they do most undoubtedly take a part. . . . . He proposed the health of the physicians to the Hospitals.

Dr. Cholmeley returned thanks on behalf of the physicians to Guy's Hospital. He adverted to the domestic calamity which had occasioned the absence of Dr. Babington and Dr. Bright.

The Chairman next gave, "The Surgeons of St. Thomas's and Guy's Hospitals." This toast was followed by three distinct rounds of applause.

Mr. Green responded. He alluded to the loss of two most valuable colleagues by the resignation of Mr. Forster and Mr. Lucas, Surgeons to Guy's Haspital.

Mr. Fitzwilliam gave a comic song.

The Chairman proposed "The Professors in the School of Medicine, Surgery, and the branches of Natural Philosophy at St. Thomas's and Guy's Hospitals." The toast was drunk with applause.

Dr. Blundell returned thanks on behalf of the professors, who occupied a position of great responsibility. The applause of such a body of men as he had now the honour of addressing, comprehending so much of the rank and talent of the profession, both established and rising, consisting as it did of so many men of vigorous and enlightened understandings, all banded together for the purpose of promoting the welfare of their invaluable institutions, could not fail to operate as an encouragement to the professors, to excite their energies and recruit their strength. There were some persons who thought that the star which had so long shed its splendour on the united hospitals was losing its ascendancy, and that the sun of medicine was fast sinking into the Western hemisphere, to be soon plunged for ever into the interminable empire of darkness. Let the proceedings of that evening convince them of their error. Those institutions stood fast, firm, and immovable, like the pyramids of old; and, like their prototypes of Egypt, he doubted not they would survive the wreck of time, and smile amid surrounding desolation. He begged leave to drink all their healths, and trusted he should always find them as jocund, as good-humoured, as united, as pleased, and as communicative of pleasure as he found them on the present occasion. (Applause.)

Dr. Blundell shortly after left the hall. As he passed along the passage between the side tables, he extended an arm in a very urbane and graceful manner, and shook hands with all the students who availed themselves of the proffered courtesy.

Mr. Green rose to propose a toast. There were some feelings, he observed, so delightful to the human breast, that whenever any occasion occurred which was calculated to call them forth they could not fail to feel the highest gratification. . . . There were lights as well as shades in life, and youth was the period of our brightest and gayest hours.

Here the learned gentleman entered into an analysis of the sentiments of the heart, in which we profess our inability to follow him, or rather to collect the precise scope and meaning of his observations. He spoke of some persons who merely assumed the garb of friendship, and threw a polish or varnish over their general conduct, under which it was scarcely possible to detect their true character. These persons, he observed, would give you a hearty squeeze of the hand, and were extremely liberal of their protestations of regard and attachment, which they put on like their dress clothes. The learned gentleman proceeded to contrast thes persons with others, whom he described as glowing with all the generous and gladsome feelings of boyhood, when the mind was occupied with few thoughts beyond the pursuits of a butterfly. After a variety of observations of this kind, he concluded by proposing the health of Mr. Travers, the Chairman. The toast was drunk with great applause.

The Chairman returned thanks. He complimented his learned friend, Mr. Green, on the acuteness he had displayed in detecting indications of character, and on the extraordinary eloquence with which he had unfolded his views on that subject. . . . He begged leave to wish long life and prosperity to all present.

Master Smith sang "Home, Sweet Home," in a very charming style, and was warmly applauded.

The Chairman next gave, "The Demonstrators of Anatomy at St. Thomas's and Guy's Hospitals, Mr. Bransby Cooper and Mr. South. The toast was drunk with applause.

Mr. South replied.

Mr. Broadhurst sang "Scots wha' ha'e wi' Wallace bled" very effectively, and was encored.

Mr. Colman proposed the health of Sir Astley Cooper. . . . . He had watched the progress of that distinguished individual from the earliest period of his career. Uniting as he did the most amiable manners with talents of the highest order, no man had in his earlier years, contributed more to the social pleasures of all who had the happiness of knowing him, but though no man was more convivial after dinner, and in the evening, he was always to be found paying the most active and devoted attention to his professional duties in the morning. He had the greatest pleasure in proposing the health of a man who had shed a lustre on the profession to which he belonged, and in that pleasure he doubted not that all who heard him would fully participate. The toast was drunk with enthusiastic applause.

The Chairman proposed the healths of Messrs. Lucas and Forster, late surgeons of Guy's Hospital. The toasts was received with applause.

Some other appropriate toasts were drunk, and the conviviality of the company was kept up till a late hour.

We would suggest to the proprietor of the Freemasons' Tavern, when he next provides a dinner for the members of our profession, to remember that we are bound, by virtue of our calling, to take cognizance of all noxious potions, and that we cannot be supposed to have a less regard for our own stomachs than for those of our patients. The stomach-pump, we really think, might be beneficially employed after a dose of tavern wine.

Reviews, etc.

Books for review should be addressed to The Editor, Gazette Office, Guy's Hospital, S.E. Their price should in every case be stated.

Rhinology. By Dr. P. Watson Williams. (Longmans, Green & Co. 12s. 6d. net.)

When reading Dr. Williams' authoritative text-book on the nose and throat we have often wondered why it has been out of print for years. Be that as it may, the treatise on rhinology is an amplified version of the first half of the above book, and is to be followed by a similar volume on laryngology.

For reasons which are not obvious, nose work has become increasingly important in general practice, and we very strongly recommend this book to students and practitioners alike, and consider that every "throat dresser" should possess himself of a copy.

The section on the anatomy of the nose and accessory sinuses is very clear and well illustrated; indeed, the illustrations throughout have reached a high standard. Special care and originality has been shown in the production of nearly fifty stereoscopic views illustrating the subject, and a stereoscope can be purchased specially for these views at an additional outlay of half-a-crown. An excellent illustration which we specially noticed shows exophthalmos from cavernous sinus thrombosis, following sphenoidal sinus suppuration.

Dr. Williams comments on the difficulty experienced in passing a frontal sinus catheter, even after the removal of the anterior end of the middle turbinal, as it may so easily lodge in an anterior ethmoidal cell, and successful passage can only be confirmed by the use of a skiagram.

The author, in comparing the fluid excreted in nasal hydrorrhœa with cerebro-spinal fluid, mentions that the latter loses its reducing power when allowed to stand for a day or two, whereas the former does not—a useful distinction.

We were surprised to find that in the operation for tonsils and adenoids, removal of the pharyngeal growth is advocated *first*, because "once the tonsils are cut the bleeding must be very profuse for some minutes," and Dr. Williams recommends pressure on the nasopharynx by a tampon while the tonsils are removed. At Guy's the guillotine is always used before the curette, and when the child is turned on its side as a preliminary to the use of the adenoid curette, the blood from the tonsils is seen to flow out from the anterior nares; we think it must be more difficult to remove tonsils when the mouth is occupied by a naso-pharyngeal tampon, as well as by a gag.

When cauterizing the inferior turbinate for chronic hypertrophic rhinitis, the dresser will do well to remember that the object of the proceeding is to produce a "linear cicatrix which binds the superficial mucosa to the deeper tissues and periosteum." The author has tried cataphoresis for atrophic rhinitis, employing metallic ions (copper, zinc, and magnesium) "with a fair measure of success."

The technique of paraffin injections for nasal deformity is described, and statistics of the operation as performed in America are given. Out of 1,452 cases there were 1,198 successes, and 106 unsatisfactory results—two of which resulted in blindness, 55 in sepsis and extrusion of the paraffin, and in 29 cases the paraffin lodged in the wrong place.

The excellent print, binding, and illustrations of this book all help to make it most readable, and the matter is so admirable as to need no further recommendation from us.

The Year Book issued by the Students' Representative Council of London University has just been published, and copies may be obtained at the Medical School Office. The Year Book contains accounts of the various Colleges and Schools of the University, and particulars of the different students' societies. In the introduction a short account is given of the work of the Students' Representative Council in co-operation with similar bodies at other Universities.

Papers, etc., Received.

"The Intensive Treatment of Syphilis and Locomotor Ataxia by Aachen Methods." By Reginald Hayes, M.R.C.S. Reprinted and revised from the *British Medical Journal*, Sept. 11th, 1909. (John Bale, Sons & Danielsson.)

"On Puerperal Amaurosis." By Sydney Stephenson, M.B., C.M., Ophthalmic Surgeon to Queen Charlotte's Hospital. With a note by W. P. Herringham, M.D., F.R.C.P. (Reprinted from *The Ophthalmoscope*, March, 1910.)

W. & G. Foyle's Selected List of Medical Books, 135, Charing Cross Road, W.C.

"Therapeutical Notes on New Remedies and Special Pharmaceutical Preparations," manufactured by Messrs. C. J. Hewlett & Son, Ltd. 3rd Edition. Copies of this booklet will be sent free, on request, to any qualified medical practitioner.

The Treatment of Nervous Diseases by Simple Electrical Methods.

CLINICAL LECTURE BY Dr. HERTZ.

Gentlemen,—I propose to speak to you to-day about the treatment of nervous diseases by such simple electrical methods as can be carried out at home under medical supervision by the patients themselves or by their friends.

It is important to realise that the indications for electrical treatment are strictly limited, and that it is not the cure-all which some enthusiasts would have us believe. When used for conditions in which it is unsuitable, it only brings the method into discredit.

The conditions for which electricity is useless are mainly chronic diseases of the central nervous system, depending on progressive degenerative processes, which nothing can stop. The commonest are tabes, general paralysis of the insane and disseminated sclerosis. To this group of diseases we may add the various forms of primary muscular atrophy.

In any case in which it is decided to try electrical treatment it is best to give it every day, and in many cases even twice a day. From ten minutes to half an hour is generally sufficient, as muscles become easily exhausted when stimulated electrically. The treatment should be continued as long as any improvement occurs; in some cases of peripheral neuritis and infantile paralysis this may even be for two or three years.

It has been said that it is not worth while treating children with infantile paralysis by means of electricity, because it frightens them so much that it cannot be properly done. But if the treatment is given with tact and begun gradually, children do not mind it in the least, and after a time they take actual pleasure in the treatment. At the first sitting let the child get used to the apparatus, but use no current at all. Next time use only a very weak current, and then on subsequent occasions gradually increase the current to the required strength. In the last three years only one child has had to be sent away from the Electrical Department without treatment, because it was impossible to keep him quiet.

The main indication for electrical treatment is in cases of disturbance of motor functions, especially those due to lower neuron lesions. The lower neuron consists of the anterior cornu cell and its nerve-fibre. When any part of the neuron is injured or diseased, degeneration rapidly occurs in the nerve-fibre peripheral to the lesion. If the injury or disease is severe enough to cut off absolutely the muscle supplied by the neuron from the central nervous system, this degeneration becomes complete within ten days. If the cause of the injury or disease disappears spontaneously or as a result of treatment, and if the nerve-cell is not completely destroyed and the continuity of the nerve-fibre not irreparably broken, gradual regeneration of the degenerated nerve-fibre occurs. Meanwhile the muscle-fibre supplied by the neuron is cut off from all impulses from the central nervous system, so that it slowly degenerates, but many months or even years elapse before the muscle-fibre disappears completely. When regeneration of the nerve-fibre has progressed sufficiently for it to carry motor impulses, the muscle-fibre will be stimulated to regenerate. But the rapidity with which regeneration will take place in the muscle-fibre depends upon the degree of degeneration which has occurred. The object of electrical treatment is to maintain the nutrition of the muscle during the period that no normal stimuli reach it, so that degeneration should be kept at a minimum. The only other means by which this can be done is by massage, and the combination of electricity and massage is best of all. By means of these the muscles supplied by the diseased or injured lower neurons are kept in good condition, so that they will at once be able to respond to the first feeble impulses which pass down the regenerating nerve-fibres.

Lower neuron lesions can be divided into diseases due to a lesion of the cells of the anterior cornua of the spinal cord and those due to disease of the peripheral nerves. In the first category acute anterior poliomyelitis is the most frequent, and it benefits greatly from electrical treatment. Degeneration of the anterior cornu cells, such

as occurs in progressive muscular atrophy and the much more common amyotrophic lateral sclerosis, can derive no permanent benefit, as the changes in the spinal cord are progressive and cannot be influenced by any known means. Some good may perhaps be done by keeping the muscle-fibres, which are not yet paralysed, in as good a condition as possible by electricity, but voluntary muscular activity by means of exercises is more effective.

Recent investigations have shown that the overgrowth of neuroglia, which is the cause of the symptoms of syringo-myelia, can be inhibited and even caused to diminish by the direct application of X-rays to the spinal cord. The lower neuron paralysis of the hands should be treated electrically at the same time. We have at present a case under treatment, in which the disease had rapidly progressed until the patient came into the hospital. Not only has the progress been arrested, but definite improvement has taken place in the eight months during which he has been treated with X-rays and electricity.

All cases of neuritis and injuries to nerves associated with paralysis are likely to benefit by electrical treatment. Facial paralysis is generally due to neuritis, and there is little doubt that recovery from this condition is considerably accelerated by the application of electricity.

Before starting electrical treatment for a lower neuron lesion, it is useful to test the electrical reactions. This not only tells you what treatment is likely to be most valuable, but it gives very useful information as to prognosis. A muscle only contracts to faradism when the nerve-endings in the muscle are not degenerated. Muscle without nerve does not contract to faradism; but muscle, whether its nerve-supply is intact or not, contracts to galvanism, so that, as long as any muscle fibres are left, they will contract at the make and break of a galvanic current. The best time to test the electrical reactions is a fortnight after the disease began or the injury took place, for it takes a fortnight for the degeneration to become complete. If at the end of a fortnight the muscle reacts well to faradism, even if it is completely paralysed, you can tell the patient that he will probably recover in a month. But if a much stronger faradic current is wanted on the paralysed side than on the other, you can say that the patient will certainly get well, but it may take two or three months. When you find the reaction of degeneration,—complete absence of reaction to faradism and certain changes in the reaction to galvanism,* you must give a worse prognosis. It will probably take as long as six months for complete recovery to occur: possibly recovery will never occur. If you find that the muscle does not react to faradism, it is not worth while treating that muscle with faradism: only galvanism should be employed. If it reacts to faradism, it is well to treat it by both faradism and galvanism. With both forms of electricity the strength of the current should be regulated so as to give the maximum possible contractions without causing pain.

The inactive electrode should be large, and placed near the seat of the disease, the cervical spine in anterior poliomyelitis affecting the arms, the lumbar spine when it affects the legs. In a case of injury to a nerve the inactive electrode should be placed near the seat of injury. For facial paralysis the inactive electrode is placed over the mastoid process. The active electrode can be arranged in various ways. The simplest method is to insert it in a bath, in which the paralysed limb is placed, so that the water acts as a large electrode, and all the muscles are stimulated. In the case of children with paralysed legs we have used in the Electrical Department a very large jug, in which the child can stand. One electrode is placed on the spine, and the other is put in the water. If, as in the case of the face, a bath cannot be used, it is necessary to put the active electrode on the muscles, preferably where the nerve enters the muscle—the motor points; at these points a contraction is produced most readily. In the case of the constant current (galvanism), as long as the current passes through a muscle there is no contraction; this only occurs on making or breaking the current. With galvanism, there-

* Slow contraction instead of twitch, A.C.C. > K.C.C. instead of K.C.C. > A.C.C., and at first increased excitability.

fore, we have continually to make and break, or, what is better, to reverse the current. Or, when a bath is not used, the active electrode can be a sponge, which is moved up and down over the muscle; by this means the current is constantly being made and broken at each point.

With regard to upper neuron motor lesions, the use of electricity is very limited. We have to consider hemiplegia and monoplegia due to cerebral disease, and spastic paraplegia due to spinal disease. But in most instances more harm than good is done by electrical treatment. The only cases of this class which can be benefited are those of cerebral origin, in which at least five weeks have elapsed since the onset of the disease, recovery has been unexpectedly slow, and there is no great spasticity. If there is much spasticity, electricity will increase it. In suitable cases the electricity acts more mentally, I think, than in any other way. The patient, seeing his muscles contract, realises that they are still capable of contracting. He becomes more hopeful, and at once makes greater efforts to move his paralysed limbs. In few cases is it worth while going on with the treatment for more than a month, as if there is going to be any improvement it will occur in the first few weeks.

In a number of spasmodic motor disorders a certain amount of good can often be done by electrical treatment. The most important of these conditions are facial spasm, spasmodic torticollis and writers' cramp. The object of treatment is to diminish the irritability of the muscles and their motor nerves. This can be done by means of anodal galvanism, because it is a well-known physiological fact that the passage of a current through a muscle or nerve diminishes the excitability of the part in connection with the anode. In spasmodic torticollis it is worth while combining anodal galvanism over the muscles, which are abnormally active, with faradism over the opposing muscles, which, as a rule, work too little. One cannot do very much for writer's cramp by electrical treatment; the main treatment is rest and re-education in writing. But when there is any pain, some good can also be done by anodal galvanism, the kathode being put over the brachial plexus or cervical spine, and the anode in a basin, in which the forearm and hand are placed.

The majority of sensory disturbances, whether due to organic or functional disease, are benefited by electrical treatment. The most important are neuralgia and those forms of neuritis in which there is pain. Sciatica is the commonest of these conditions; it is probably generally due to neuritis, but occasionally neuralgia. Similar conditions in the arm—brachial neuritis and neuralgia—are rather less common. A third important disease of this sort is trigeminal neuralgia. The electrical treatment for these and for similar conditions in other parts of the body is the same in principle. As these cases are very often intractable, it is important to learn more than one method of treatment, so that if one fails, you can resort to others. Treatment by means of galvanism is most commonly employed. It is important to instruct the nurse, or whoever is carrying out the treatment, that it is unnecessary to produce muscular contractions. The object of the treatment is, as in spasmodic conditions, to diminish the excitability of the sensory nerves. Anodal galvanism must therefore be used. The electrodes should not be moved, and the current should be allowed to run without interruption. It should be slowly increased up to the maximum strength, and at the end of treatment slowly reduced to zero. In the case of superficial nerves only a weak current is required; with deeper nerves, as in sciatica, a comparatively strong current—30 to 50 milliampères is needed, but in such cases it is important to use large and well-padded electrodes in order to avoid injuring the skin. For sciatica, the indifferent electrode is placed over the sacrum or sciatic notch, and the anode over the most painful part of the nerve.

Another very effective method of treatment is by cataphoresis; I have now seen several cases of trigeminal neuralgia saved from operation with its aid. Cataphoresis means ionic medication—drugs being driven direct into the painful nerves by electricity. Salicylates and quinine given by mouth are often valuable in neuralgia, and their effect is much greater when introduced into the painful part in a concentrated form by cataphoresis. Quinine is driven in from the

anode, but acid radicals, such as salicylic acid, are driven in from the cathode. In most cases, therefore, quinine is the best drug to use, as with it the sedative effect of simple anodal galvanism can be combined with cataphoresis. The electrode consists of several layers of lint soaked in a 2 per cent. solution of bichloride of quinine and applied exactly as in treatment with simple galvanism. In trigeminal neuralgia it is advisable to use as large an electrode as you can, and to put it over the side of the face, because even if the pain is localised you can use a stronger current without causing trophic changes. If simple galvanism and cataphoresis fail, high frequency treatment occasionally helps, especially in sciatica.

There is one common sensory disturbance—tinnitus—which is rarely treated by electricity, but in which we have several times obtained satisfactory results in the Electrical Department, although one cannot influence the underlying organic disease. The patient can carry out the treatment himself quite easily for a few minutes every day. The anode is placed over the mastoid process and as strong a current should be used as can be passed without producing discomfort. The sounds often disappear during the treatment, and sometimes stay away for several days.

The next great class of cases are functional nervous disorders. For neurasthenia simple electrical applications are rarely of any use. But many patients with neurasthenia benefit from static electricity, largely as a result of suggestion: there is the elaborate apparatus, the smell of ozone, and the sparks and noise. Static electricity has the power of raising the blood-pressure, and in neurasthenic conditions the blood-pressure is often low. Probably, therefore, the treatment owes some of its success to its action on the circulation. Half an hour's treatment daily should be given. The patient should receive a positive charge, and a negative breeze can be passed over the spine by means of a special electrode. A tassel electrode produces an electric breeze over the head, which is extremely useful for neurasthenic headaches and insomnia. The insomnia of granular kidney can be benefited by the high-frequency current, for this produces a fall in blood-pressure.

The other important functional condition which we have to consider is hysteria. For this, electrical treatment in itself is absolutely valueless; it is the greatest mistake in such cases to leave the treatment in the hands of the nurse or relatives, for its entire value depends on suggestion. If you do not cause improvement in the first sitting you will probably meet with no success later. Hysteria is an abnormal mental condition, in which the individual is abnormally subject to suggestion, so that symptoms of all sorts are produced by auto-suggestion, and can be produced by suggestion on the part of others. Being produced by suggestion, the symptoms can invariably be caused to disappear by suggestion. And there is no more powerful means of suggestion than electricity. First talk to the patient, and persuade him that he will get well rapidly. Any form of electricity which is painful will do. The simplest and best is probably faradism, a wire brush being used as the active electrode; the current should be as strong as the patient can bear. The brush should be rapidly put on and taken off the muscles, or moved rapidly up and down. If the patient's mind has been properly prepared you will get wonderful results. But he must be previously convinced of the efficacy of the treatment. These remarks apply to any hysterical manifestation, such as paralysis of limbs, functional aphonia, or contractures. Many of you will have seen, at my last two demonstrations of nervous cases, two patients of Mr. Dunn's, both suffering from traumatic hysterical hemiplegia. Both were firmly convinced that they were about to be cured, and both were able after a single treatment to wheel the couch, on which they were brought into the theatre, back into the ward.

The last conditions I want to speak about are vaso-motor disturbances. It is not quite accurate to call them nervous diseases, but some of them seem to depend on vaso-motor spasm, due to abnormalities of the nervous supply of the blood-vessels. The most important of these diseases is Raynaud's disease, which is due to vaso-motor spasm; closely related to this is acroparæsthesia,

in which there is discomfort or a sensation of pins and needles in the tips of the fingers, and sometimes in the toes. They are extremely unpleasant conditions, and very difficult to treat by any other means. In other vaso-motor diseases, such as erythromelalgia, there is extreme vaso-dilatation instead of vaso-constriction. All these conditions are greatly benefited by electrical treatment. The patients are often better only so long as the treatment is continued, and therefore it is well for them to get a battery for themselves. Each hand or foot should be immersed in a basin of water, one electrode being put in each basin, so that the current passes through the body. Faradism given in this way is the most satisfactory treatment for chilblains, even if the surface of the skin is broken. In severer conditions, such as Raynaud's disease and erythromelalgia, galvanism with frequent reversals is better than faradism, but the combined galvanic and faradic current is best of all. The treatment should be given every morning and evening, and again during the day in case of a bad attack. Sometimes complete recovery results after prolonged treatment, but for chilblains and Raynaud's disease it is wise for some years, as soon as the winter sets in, to recommence treatment, even though there may not be any return of symptoms.

Appointments.

University of Oxford, March, 1910.

Radcliffe Travelling Fellowship.

The electors have appointed Mr. E. L. Kennaway, B.M., M.A., Hulme Research Student of Brasenose College.

University of London.

Appointed Staff Examiners for 1910—1911.

Forensic Medicine and Hygiene: Professor H. J. Campbell, M.D.

Medicine: G. Newton Pitt, M.A., M.D.

Civil.

Fortescue-Brickdale, J. M., M.A., M.D. Oxon., has been appointed Physician to Clifton College.

Killard Leavey, T. J., L.R.C.P., M.R.C.S., has been appointed house surgeon for one year to the Herefordshire General Hospital.

Webber, H. W., M.D., M.S. Lond., has been appointed Honorary Surgeon to the South Devon and East Cornwall Hospital, Plymouth.

Military.

Captain R. Tilbury Brown, M.D., R.A.M.C., has been selected for the appointment of Sanitary Officer, Burma Division.

The Aetiology and Pathology of Pigmentation in Constitutional Disease.

The Treasurer's Prize Essay.

Guy's Physical Society, 1910.

By Frank Cook, B.Sc.

The subject of pigmentation is of interest alike to chemist, physiologist and clinician. Here, at least, the pathway from laboratory to bedside is clear, and in the main unbroken. Gaps still exist—but many have been bridged; and, with analogy to lead the way, few can withstand the strides of common-sense; none debar the leap of slenderest imagination. So, we glance into a medicine of the future, when symptoms serve but to reflect the work of agencies beneath, whereof the furthest nature is revealed, whereon all treatment finds foundation.

The first part of this paper deals with Pigments, the second part with Pigmentation.

1.—The Nature and Origin of the Pigments.

On first consideration it appears unscientific to group together a series of substances whose only common attribute is coloration: colour is characteristic of no single chemical class. Yet a review of those pigments exhibited by the human body in health and disease at once reveals a general alliance, which is strengthened on closer examination. The results of investigation, though scanty in part, seem to indicate that body pigments, other than the direct derivatives of hæmoglobin, have a common relationship to the benzenoid group, whilst there is reason to believe that some connection exists between these and the blood pigment itself. There are others without either category, but neither in quantity nor in importance do they warrant departure from a simple classification.

The functions of pigments do not immediately concern a subject which deals with pathological processes rather than teleological explanations, though they are worthy of passing attention. In the lower animals, pigments are respiratory, attractive and protective in nature. In man, their physiological properties are mainly respiratory; the attractive and protective properties have largely, though by no means entirely, disappeared.[1] In one case, especially, pigmentation provides an almost perfect protection from an element of the environment: the negro's skin is thereby adapted to withstand the irritation of the sun's most injurious rays. This particular

1 It is of some interest to note that this decay of function coincides to a certain extent with the disappearance of chromatophores from classes higher than Reptilia; the exclusive function of these cells is to contain pigment and give coloration to the animal.

function is of secondary importance in another connection, and will so meet with further reference, but the question of function in general must yield to that of chemical structure and relationships.

Hæmoglobin, as the mother substance of a whole class of pigments, and as one which itself exhibits certain pathological manifestations, demands first consideration. Apart from the suggestion that hæmoglobin is a derivative of the melanins, its origin is entirely vague. The structure is revealed by a successive description of its analytical products, natural and artificial. Oxyhæmoglobin differs but slightly from hæmoglobin itself. Methæmoglobin is formed from oxyhæmoglobin with the greatest ease, for which reason it is so frequently found in the urine in conditions of hæmoglobinuria. This pigment probably represents an intermediate stage in the formation of hæmatin, the first step in the cleavage of the hæmoglobin molecule, which results from the separation of globin, an unimportant protein radicle.

Hæmatin retains the chromatic constituent of hæmoglobin and also the whole of the iron. Physiologically, it is formed in the liver; pathologically, it may be formed in hæmorrhagic areas, where, by further disintegration, it gives rise to a series of pigments from which the iron is gradually extruded. Thus, there is a progressive transition from hæmatin with its full complement of iron to hæmatoidin which is iron-free. This is well exemplified by the succession of tints assumed in an area of subcutaneous hæmorrhage. Only three pigments of the series have been differentiated, and to them the names hæmosiderin, hæmofuscin and hæmatoidin have been given. Hæmosiderin is an amorphous compound which contains iron in loose combination, and is therefore readily identified; it occupies the outer zone of hæmorrhagic areas. Hæmofuscin generally accompanies hæmosiderin; whether this pigment contains iron in firm combination or whether it is iron-free is undecided; it shows no reaction to the micro-chemical tests for iron. Hæmatoidin is definitely iron-free; it is ruby-red in colour, and is found in crystals or granules in the centre of large areas of hæmorrhage. Such are the immediate derivatives of hæmatin formed essentially in the body. There is very little difference between hæmatoidin and hæmatoporphyrin which may be prepared in vitro. Hæmatoporphyrin is iron-free; in some animals it occurs freely as a physiological pigment; in man, minute quantities appear as a normal constituent of the urine, whilst a considerable output may accompany morbid conditions.

Chemically, hæmatoidin and hæmatoporphyrin are closely allied[2] to bilirubin and its oxidation product biliverdin, the chief pigments of the bile[3]; but physiologically there is an essential difference, for, in spite of long-continued controversy, it seems clear that bilirubin and biliverdin are formed only by the agency of hepatic cells, whilst under certain conditions the nearer derivatives of hæmoglobin may be formed elsewhere, though they too exist in general only as intermediate stages in the formation of bile pigment by the liver. This conversion into bile pigment is in fact the normal way of all hæmoglobin save that fraction destined to appear in the urine as urochrome. Since the usual life of an erythrocyte is only about four weeks, the work of the liver in dealing with pigments liberated therefrom is always considerable, and is enormously increased when called upon to cope with an excessive breakdown. Urochrome, too, is probably a result of hepatic activity. Although it is quantitatively the chief urinary pigment, it is of relatively little importance, and its life history is indefinite. However, it is known to be endogenous, and an origin from hæmoglobin is assumed on account of its obvious structural resemblance to the substances already considered.

That the hepatic cells are the chief agents in the formation of the bile pigments has never been doubted. But the occurrence of jaundice in various septic conditions led to the hypothesis that these pigments might also have an origin in the blood stream itself. In this way two forms of jaundice become recognised—a hepatogenous and a hæmatogenous. Further observations have revealed, however, that in all conditions of true jaundice (*i.e.*, those in which the coloration is due to bilirubin and biliverdin) the liver itself is the first organ to become discoloured. This fact proves that the seat of origin of bilirubin and biliverdin is invariably in the liver, and, therefore, that all true jaundice is essentially obstructive in character. In toxic jaundice there may be, it is true, an extensive mechanical breakdown of erythrocytes in the circulation, with the possible formation of hæmosiderin and hæmatoidin, but the final change must take place in the liver, although, through the overloading of the hepatic cells and blockage of the fine bile channels with concentrated bile, this breakdown may be an essential if indirect cause. Perhaps such a condition may be suitably designated hæmo-hepatogenous jaundice. It is imitated experimentally by the administration of such poisons as phosphorus and toluylenediamin. In hepatogenous jaundice biliary pigment is freely formed, although a suppression of bile production as a result of stasis has been frequently assumed. In hæmo-hepatogenous jaundice it is possible that the conversion of hæmatin into bilirubin fails to keep pace with the supply of blood pigment.

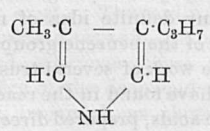
There are certain cases in which the skin assumes a tinge varying from lemon yellow to bronze or grey, and in which the liver shows no sign of pigmentation macroscopically or microscopically. In these cases the pigment is neither bilirubin nor biliverdin, so that the condition is not one of true jaundice, although the subject may be jaundiced in the original sense of the term. One of the causative factors is the toxic condition which may give rise to

2 Hæmatoidin is generally regarded as being identical with bilirubin, chiefly on the ground of a similar empirical formula; but existing evidence is insufficient to justify this assumption.

3 Under abnormal conditions other pigments appear in the bile. These are found as a rule in bile concrements and post-mortem bile. In gall-stones the following pigments have been recognised: bilifuscin, biliprasin, bilihumin and bilicyanin, besides bilirubin and biliverdin. To the successive formation of these pigments is due the play of colours in Gmelin's reaction.

jaundice proper. Two explanations have been advanced: The pigmentation observed may represent precursors of the bile pigments, hæmatoidin and its allies, or a product, in the form of urobilin. Probably both factors play a part. Urobilin appears in comparatively large quantities in the urine as an accompaniment of the cutaneous coloration. Its origin is of a complex character; it is therefore opportune that its place in the chemical and physiological series should next demand consideration. This compound is a natural reduction product of bilirubin; it corresponds to hydrobilirubin prepared from the same source by reduction in vitro, and is closely allied to, if not identical with, stercobilin, the colouring matter of the fæces. Urobilin itself is found chiefly in the fæces; in health, mere traces are found in the urine, partly as such and partly in the form of a chromogen. It is generally accepted that the necessary reduction of bilirubin is due to the action of bacteria in the intestine. According to this view urobilin formation should vary in extent with the amount of intestinal putrefaction. There is considerable evidence in favour of this hypothesis; the existence of a biliary fistula results in the disappearance of urobilin from the urine—unless bile be given by the mouth, when there is a reappearance; a diminution of bacterial activity in the intestine, which some observers claim to have induced by intestinal antiseptics, is followed by a diminution in the formation of urobilin; in typhoid fever, in which bile pigment is passed unaltered from the bowel, the urine is free from urobilin; in infants the meconium, which is free from bacteria, contains no urobilin; in cases of obstruction of the bowel, the urinary urobilin may be excessive. The evidence in favour of an intestinal origin is therefore conclusive, but Surveyor has recently thrown doubt on the bacterial nature of the reductive process, which, he considers, might equally well result from the action of some secretion of the bowel. His conclusions are not sufficiently convincing, however, to justify desertion of our former views. We may conclude tentatively that bacterial activity in the bowel is a factor in the production of urobilin. The next question to decide is whether such an enterogenous origin accounts for the whole of the urobilin found in the body. Many forms of hepatic disorder—in fact, all forms not involving a blockage of the bile ducts—are accompanied by an increased excretion of urobilin in the urine; in febrile diseases with cachexia and after internal hæmorrhages there is a marked increase. This fact has given rise to several theories of urobilin formation outside the intestine. Hepatogenous, hæmatogenous, nephrogenous, and histogenetic urobilinuria have been suggested at various times. In addition to the localisation of urobilin formation in different parts of the body, a possible origin from hæmoglobin, without the intermediation of bilirubin, is thus assumed. Although there is no theoretical reason why urobilin should not arise from the blood pigment direct or under the influence of autolytic changes in the liver, these views have in turn proved untenable. At the same time it has become obvious that an exclusively enterogenous origin is compatible with the facts observed. It is almost certain that all the urobilin absorbed is not excreted unchanged by the kidney: as in the case of the bile salts, a considerable proportion appears to return to the liver to be re-excreted in the bile, unchanged, or in the form of bilirubin.[4] In certain forms of liver disease it is conceivable that the mechanism of this circulation may be interfered with, and consequently larger quantities of urobilin excreted by the kidney. Thus we arrive at a hepato-intestinal pathogenesis of urobilinuria, in the production of which the liver plays a negative part—a part which it can adequately assume in all pathological conditions characterised by urobilinuria. Therefore an increase in the urinary urobilin may be assumed to indicate an increased production in the intestine or a diminished elimination by the liver; in the first case the increase may be due to excessive putrefaction or to an excessive supply of bile pigment. Incidentally, this variety of factors renders useless any attempt to estimate the extent of intestinal putrefaction from the degree of urobilinuria. The "pathological urobilin" of former observers merely represented any excess over the usual quantity in the urine; the supposed difference may have been due to a frequent admixture of urobilin with hæmatoporphyrin or other impurities.

Stercobilin is the only remaining pigment known to be derived from hæmoglobin under natural conditions. It is usually considered to represent a concentrated form of urobilin, but there may be a slight difference in structure. A further insight into the structure of blood pigment may be taken without the guidance of the body. Hæmatoporphyrin is found by analysis in vitro to contain hæmopyrrhol, a compound which embodies the pyrrhol ring within its molecule. Hæmopyrrhol forms a common derivative of hæmatin and chlorophyll; on exposure to air it is converted into urobilin. Its formula is probably



This discovery enables us to anticipate with confidence the synthesis of the blood pigments, and therefore throws open an entirely new prospect in the field of biological chemistry.

Turning from hæmoglobin and its derivatives we leave classification for speculation and facts for words. Yet this speculation is found to foster a hope of knowledge which the facts themselves encourage rather than destroy—perhaps because they are so few. Although widely diverse in appearance, the remaining pigments seem to show some similarity in structure. The majority are known as melanins. The term "melanin" has been used to include all the dark brown or black pigments.

4 It is also possible that varying amounts of the absorbed urobilin are converted into urochrome.

formed in the body by processes physiological or pathological in character. With the exception of this common property of dark coloration, they have no claim to be grouped apart from other pigments. Similarity of structure indicates an inclusion of further compounds in the group. But it is only of late years that structural attributes have been revealed. This has been due to the difficulty of separating pure specimens, and to the fruitlessness of research work based on the assumption that melanins are stable and alike.

Such investigations as may be considered reliable have shown that the melanins in general contain little or no iron and a comparatively large amount of sulphur. The absence of iron has been assumed to exclude the possibility of an origin from hæmoglobin; but although an origin from the blood pigment is improbable, there is no reason to deny it on these grounds. The sulphur content has been advanced in favour of an origin from protein. This is supported by other evidence, such as that derived from the products of distillation. Most observers agree that the melanins arise in some way from protein or its derivatives, but differ in attributing the chief part in their formation to aromatic compounds on the one hand and aliphatic compounds on the other. It is therefore necessary to exercise some discretion in accepting their results. Many are based upon isolated and empirical tests rather than thorough chemical examination; in different cases the oxidative process used in distillation has varied considerably in power. It is a significant fact that pyrrhol has been found in almost every case. The pyrrhol formation is found in the body in combination with a benzene ring as indol, and is also found in the hæmatoporphyrin molecule. Since the latter source of melanin is improbable, the existence of pyrrhol amongst the distillation products may point to the presence of the indol group. Although it is impossible, in view of so much conflicting evidence, to gather from the results of distillations any definite idea of melanin structure, yet the inclusion of the benzene grouping is indicated on these lines by the work of several trustworthy observers. Abel and Davies have found in the reactions of melaninic and oxymelaninic acids, prepared directly from melanins, suggestions of the presence of aromatic bodies, which are more definitely indicated on further analysis of these acids. Others have obtained indol and skatol themselves from the products of decomposition.

Further insight into the melanin structure has been rendered possible by evidence of a different type. It has been shown by Chittenden and others that the action of strong acids upon proteins produces a dark brown substance, "artificial melanin." This reaction corresponds to those natural processes, such as the browning of the cut surface of an apple, and the formation of sepia and lack lacquer, which appear to result from the action of oxidases on certain constituents of the protein molecule —probably tyrosin and other aromatic bodies. Miss Durham has shown that from the skins of young mammals, such as guinea-pigs and rats, there can be extracted in water a material which, when incubated with tyrosin, throws down a pigmentary substance. This pigment is the same as that of the hairs of the skin from which the material is extracted. Further investigations show that this material is of the nature of a ferment, for which reason it has been termed tyrosinase. The formation of the pigment, therefore, depends upon the interaction of a chromogen, similar to tyrosin in nature, and a ferment. It therefore remains to investigate the nature of tyrosinase. This has been revealed by observations on albinos, amongst others. Breeding experiments have shown that albinos carry a pigment factor of some kind. Miss Durham has found the skin of these animals to give negative results; she therefore concludes that the albino lacks the tyrosinase and carries the chromogen. Further evidence has been supplied by Mudge's observations. Assuming the fermentation to be of the nature of an oxidation or reduction, he has brought the albino skin under the influence of reducing and oxidising bodies in turn. Thus he has immersed albino rats in a mixture of formalin and spirit, which has given rise to a yellow coloration in a short time, then in hydrogen peroxide, which has deepened this colour to a brownish tint. Von Fürth, on the basis of these and other observations, has formulated a convincing theory with regard to the nature and origin of melanins. He regards their development as due to the action of intracellular oxidases upon the aromatic or chromogen groups in the protein molecule; the sulphur and iron he would regard as being secondarily combined.

Before passing on to a consideration of the benzenoid compounds—a course indicated by the foregoing conclusions—it may be of interest to inquire more closely into the nature and relations of the melanins themselves, especially as they exist in the body of man. Reference has already been made to the work of Delépine, which was designed to prove melanin a precursor of hæmoglobin. This relationship was not conclusively established, but facts brought to light in the attempt, and the deductions therefrom, have proved of the greatest value. Delépine's observations showed that the deposition of melanin in the Malpighian layers of the skin varied according to the presence or absence of certain stimuli—thermal, luminous, chemical, mechanical, or nervous. Under all ordinary conditions, one or a combination of these factors tends to maintain a constant production of the pigment. As regards light and heat, the ultra-violet rays have been shown to be far more effective in producing pigmentation than rays of lower frequency; this assigns to the purely luminous waves a greater activity than is possessed by those which display the properties of light and heat combined, or heat alone. Chemical irritants may stimulate cutaneous pigment formation from without or within; thus, on the one hand, there is the pigmentation produced by a mustard plaster, and, on the other, that produced by arsenious acid circulating in the blood. Effective mechanical stimuli may be supplied by such processes as scratching, or the friction of clothes and opposed surfaces of skin.

The nervous influence presumably represents a combination of simple forms of energy. Some degree of melanin formation has on occasion been observed to follow inflammation of the skin; this, too, would seem to operate by augmentation and union of these elementary forces, though other factors may take part. The melanin is deposited in the deep layers of the rete Malpighii. It is almost totally absent from the superficial layers of the epidermis, and yet, in spite of its great insolubility, any excess gradually disappears after the additional stimulus has ceased to act. This disappearance must necessarily follow a transformation of the pigment into some pale or colourless substance which passes towards the surface or into the subjacent tissues; from this substance Delépine considered blood pigment to arise, though further evidence is needed to lend support to his hypothesis. Melanin has generally been regarded as a derivative rather than a precursor of hæmoglobin, but there are several observations which refute this view. It appears in many embryonic parts before blood has been formed; in the adult melanin may appear in parts removed from all blood vessels; further, the amount of melanin formed in the epidermis does not depend on the amount of blood inside or outside the vessels of the subjacent tissues. The presence of the pyrrhol ring in each pigment is suggestive of some relationship.

When a large amount of melanin is produced in the skin as the result of some such process as mechanical irritation or chemical stimulation by arsenic, the pigment accumulates not only in the rete Malpighii, but also in the lymphatics of the corium. Further, an obstruction to the lymphatics of the skin results in an accumulation of melanin between the point of obstruction and the epidermis. From these facts one may deduce that melanin is formed more or less constantly by the deep cells of the rete Malpighii under the influence of some stimulus or another; in the ordinary course of events the deposit is re-converted into a colourless body which the lymphatics remove from the skin; occasionally, however, either from increased production, deficient assimilation, or obstruction of the efferent channels, it may accumulate in the epidermal cells and in the lymphatics themselves. When light is the factor responsible for an increased formation, pigment appears to a greater extent on that side of the cell exposed to its influence than on the side opposite. As the chemically active rays of the sun are instrumental in stimulating a production of melanin by the skin, so is the melanin, when formed, capable of absorbing these rays, and preventing their further ingress into the body. Two results follow from this: an increasing production of pigment is prevented, and the sensitive vascular corium is protected from the irritation which the sun's rays would otherwise produce. That the pigment should tend to form in the external part of the cells favours still further the attainment of these effects. The skin of the negro affords a well-marked example, for although the basal layer of the rete Malpighii is here deeply pigmented, and even the more superficial layers to a slight extent melanin is never found in the cutaneous lymphatics as it may be in those milder degrees of pigmentation caused by arsenic, etc. Thus, in spite of the presence of the necessary factors, a production of pigment above the normal level is prevented by that already present. Again, it has been observed that a negro's skin remains unaffected when exposed to a degree of sunlight which, under similar conditions, causes marked inflammation in the skin of a white man. Light, therefore, produces those very effects which are best adapted to annul its own further activity, and it is tempting to consider the pigmentation of the negro's skin as due to the action of light. This pigmentation is a hereditary property, however, and clearly due to evolutionary processes; these may have operated, it is true, by conferring an increased susceptibility to the influence of light, but one can only suppose the property to have originated directly from this influence by assuming the transmissibility of an acquired character.

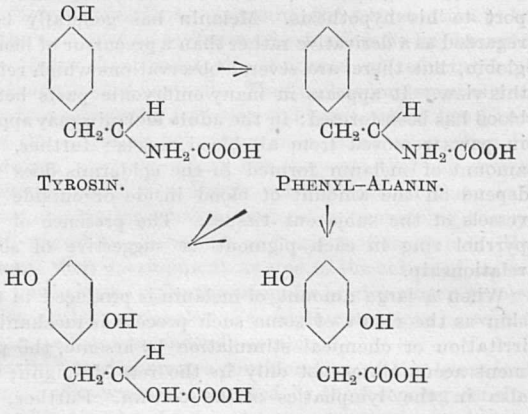
In general, from the foregoing considerations, we may induce that the formation of melanins and allied pigments depends upon the interaction of several factors—material precursors, catylases, and various forms of energy. The precursors appear to consist in part of certain benzenoid compounds. The catalytic activity appears to be oxidative in aim; it may represent a function of a class of cells or of individual enzymes, oxydases. By accepting tentatively an analogy with other forms of catalytic activity where factors of the same kind are in operation, we may assume that the catylase effects the necessary chemical process by introducing some form of energy from an external or an internal source. Thus, by utilisation of the energy of the sun's rays, an enzyme in the green leaf of a plant disturbs the equilibrium in an equation of opposing forces, and so furthers a chemical process which would otherwise barely exist. The ordinary metabolic processes to which certain organic compounds are subject may be disturbed wherever these compounds come under the influence of the deep epidermal cells or their peculiar enzymes, inasmuch as these enzymes, by the introduction of a new form of energy, divert the chemical reactions from their usual course into a side path—a path which leads to the formation of melanins.

The extent to which these pigments are formed would depend, therefore, firstly on the available quantity of their precursors, and, since that part which reaches the skin is presumably a fairly definite fraction of the whole, upon the quantity of these precursors circulating in the body; secondly, upon the degree of available energy of necessary character; and, thirdly, since the former may be subject to considerable and transitory variations, upon the catalytic power of the enzymes, and the speed with which the necessary reactions are accomplished. These merely regulate the production of pigment. It would require knowledge of a fourth factor—the extent of concurrent destruction, which in itself is indeterminable—to calculate the absolute amount deposited on any given occasion. The latter, however, may be observed direct;

and since it is with the causation of variations that we are chiefly concerned, a further inquiry into the productive agents is likely to be of some value. It is of the material precursors alone that we can claim any knowledge; the physical and "biotic" forces involved are still vague entities.

Assuming that the aromatic bodies participate in melanin formation, we may well investigate the condition under which these compounds appear in the body. Three amino acids are known to contain a benzene ring, tyrosin, phenyl-alanin, and tryptophane; in the ordinary way all the aromatic compounds of the body have an origin from one or other of these. They are formed by proteolysis in the intestine from the proteins of the food, and occasionally in the tissues from the proteins of the cell. When absorbed unaltered through the intestinal wall, they are completely broken down in the course of metabolism, and there is consequently no reappearance of the benzene grouping in the urine. When bacteria effect a preliminary change in the gut, stable combinations are formed capable of resisting further metabolic alteration. These are no longer physiological to the organism, and if absorbed necessitate the introduction of a mechanism which may lessen their toxicity. To this end the body usually effects a union with a sulphuric acid radicle, or occasionally with glycuronic acid in its place. It is therefore as an "ethereal sulphate" that the benzenoid nucleus is generally excreted. Although tyrosin is chiefly absorbed without bacterial impression, it may give rise to a considerable group of aromatic bodies in the urine; phenol, parakresol, and dioxyphenol, with mandelic, uroleucic, homogentisic, and other acids. Phenyl-alanin is represented in the same way by phenyl-acetic, phenyl-propionic, homogentisic, benzoic, and hippuric acids. Tryptophane is responsible for the appearance of skatol acetic acid, skatol, indol, skatoxyl, and indoxyl compounds. Presumably aromatic in common with other amino-acids may arise not only in the gut, but also in the tissues; it is therefore logical to suppose that the ethereal sulphates may have an alternative or endogenous source, though this possibility has received little or no support from experimental observations. Failing evidence to the contrary, however, it is not strictly justifiable to regard the benzene compounds of the urine as a measure of bacterial decomposition in the intestine, particularly as the extent of absorption is a variable factor; though they doubtless give some relative indication. Indican itself is shown to be of origin purely enterogenous.

A condition has been observed in which the metabolism of the aromatic bodies deviates in part from its normal course, or stops short before the normal end is reached. This process is peculiar to certain individuals, who frequently show no further abnormality; it is of interest to physiologists in lighting up a hidden phase of metabolism, whilst it is particularly interesting in the present connection, inasmuch as it gives rise to a singular pigmentation of the urine, and occasionally of other parts of the body. The urine of persons possessing this peculiarity is characteristic in containing considerable amounts of homogentisic acid, and occasionally uroleucic acid also. These are increased by the administration of tyrosin and phenyl-alanine. Since the extent of their excretion varies with that of total nitrogen, whatever the quantity of protein in the food, they arise from internal metabolism. In normal men the aromatic ring of homogentisic acid taken by the mouth disappears almost entirely, just as it does in tyrosin and phenyl-alanin. But in cases where homogentisic acid is habitually excreted, ingestion of the same substance is followed by a quantitative reappearance in the urine unchanged. Therefore, tyrosin and phenyl-alanin are normally oxidised to homogentisic acid, which is further split up; but in these abnormal individuals the ring, when formed, fails to break down further.



Tyrosin. Phenyl–Alanin.

Uroleucic Acid. Homogentisic Acid.

Not only do the aromatic compounds take part in the formation of melanins proper, but under certain conditions they may, with slight modification, assume the character of pigments themselves. To homogentisic acid—and possibly to uroleucic also—is due the condition known as alkaptonuria, in which a black or brown pigment is formed in the urine, either by the addition of alkalis with simultaneous absorption of oxygen, or merely by exposure to the air. Although it is with great rarity that the urine is actually pigmented with indigo blue, little change is required to convert indoxyl into this pigment, or its isomer, indigo red; the process consists of a simple oxidation. Indoxyl is almost invariably present in the urine in the form of indican or indoxyl sulphate, however, and thus the necessary oxidation is avoided. Carbolic acid poisoning is followed by a greenish-brown coloration of the urine, which darkens further on exposure to air. This, too, is due to the oxidation of aromatic bodies, which appear in excess as an accompaniment of the phenol itself. Foregoing considerations appear to indicate a kinship between these pigments and the melanins of other parts.

Lipochromes and other pigments exist in the body in appreciable quantities, but little is definitely known of their nature or origin, and even less of their variations in disease.

(*To be continued.*)

Sport.

Association Football.

GUY'S v. BART.'S.

Inter-Hospital Cup. Final Tie.

Played on the London Hospital ground, at Hale End, on Tuesday, March 22nd, when Guy's succeeded in retaining the Cup by the only goal in the match. The team are to be congratulated on gaining this trophy for the fifth time in succession, thus creating a record.

The start was sensational, as Guy's, playing against the wind, set up a strong attack, and Bergh, who has a natural aptitude for finding himself in the right place, took a neat pass from Birks, and scored the only goal within three minutes of the start. After this the game was fast, even, and very vigorous. Play was chiefly in midfield, where plenty of good football was seen, but neither side ever really looked like scoring, as the defence on each side was very sound.

Early in the second half Dale (Bart.'s) and Kyle were both injured, the latter being rendered a passenger for the rest of the game, and there were plenty of hard knocks given and taken. Barrow and Waugh, well fed by Dyas, required a lot of attention, and got it, from Bastard and Crook, while the Bart.'s backs, Rimington and Stretton, were both playing splendidly.

The game needs little description, everyone played his hardest in a good sporting spirit, but special mention should be made of King, who for the last twenty minutes played as an extra centre-half, and did splendid work in keeping out the Bart.'s forwards. Rook made two very good saves, but otherwise had nothing to do. Bastard was quite at his best, and is a great cup-tie player. Keer, after a shaky start, settled down and supported him admirably. Crook did splendid work all through in attack and defence. Neely gave a vastly improved display, and looked well after his man, besides setting his wing going nicely, and Kyle was doing well till he unfortunately got "crocked." The forwards found combination difficult in the first half against the wind, and afterwards the four of them were rather outplayed by the two excellent backs against them. Bergh and Birks were the best; the latter's dribbling was quite a feature. Jones was always bustling, Bevis got in some good centres, but was a bit slow, while mention has already been made of King, who did an extraordinary amount of good work towards the close. Team :—

Guy's.—H. C. Rook (goal); H. R. Bastard, K. J. T. Keer (backs); J. Kyle, A. H. Crook, H. B. Neely (halves); R. M. King, V. E. D. Bergh, T. L. Jones, A. H. Birks, S. W. Bevis (forwards).

Referee: Mr. P. R. Harrower.

The thanks of the team are due to the Residents for the lavish hospitality extended to them at dinner (Mr. H. Lee in the chair), and subsequently in the Charities' Room, where they were regaled with song and hot punch. The evening was thoroughly enjoyed by all, and the kindness of the Residents much appreciated.

GUY'S 2nd XI. v. St. THOMAS'S 2nd XI.

Inter-Hospital Junior Cup. Final Tie.

Played on the London Hospital ground, on Monday, March 21st. Guy's won the toss, but gained little advantage, as there was neither wind nor sun.

Straightway from the start Thomas's made a most determined attack on Guy's goal, and it was at once evident that the defence would have their work cut out to keep them from scoring. It was not long, however, before Guy's forwards got the ball and made tracks for goal, and for a short period the ball was kept in our opponents' half. Thomas's forwards soon returned with the ball, and combining well repeatedly came up the field, and Rhys-Evans had to save on several occasions, though there was not much sting about the shots sent in. Our opponents continued to have the upper hand for a spell, and from a centre from the left one of their forwards rather unexpectedly turned the ball into the corner of the net, well out of Rhys-Evans' reach. This woke Guy's up, and the forwards gave the opposing defence a busy time. This was relieved by a shot from Wain hitting the cross-bar and bouncing over. For the rest of the first half play was fairly even, and everyone was glad when the whistle went for half-time, as the play had been very fast all through. Half-time: St. Thomas's, 1; Guy's 0.

After half-time it was soon evident that our opponents were tiring, especially their forwards, and with the backs landing the ball well up the field the forwards had more chances, and on several occasions, had the shooting been good, goals must have been scored. Their efforts, however, were soon rewarded, Wain scoring from close quarters. Thomas's were not long in assuming the offensive again, and Rhys-Evans did well to save quite a number of good shots with their inside forwards very anxious to bundle him into the net. Hereabouts, our opponents' outside left got clear away, and when close to goal hooked the ball into the goal mouth for it to be pushed into the net by one of the insides. He was hustled, however, by one of the backs before he centred, and the ball had clearly gone over the goal-line, so a goal-kick was given. Guy's then took up the game and pressed till time, when the score stood: St. Thomas's, 1; Guy's, 1.

It was decided to play a quarter of an hour extra each way, though many of the players had evidently had about enough, and everyone was a bit exhausted.

Both sides made desperate efforts to obtain the deciding goal, and, with our opponents' defence weakening, our forwards very nearly succeeded on more than one occasion. Time, however, came with no alteration in the score, though Guy's had undoubtedly had the better of the closing stages. Team :—

Guy's.—J. E. Rhys-Evans (goal), C. D. Neal and C. E. Rice (backs), V. F. Golledge, J. A. Edmond, E. L.

Jones (half-backs), A. F. Camp, D. Wain, W. Matthews, G. W. King, E. G. McClymont (forwards).

Remarks.—A most strenuous game. The teams were very evenly matched, with Thomas's the more scientific and Guy's the more bustling. The whole team played well. Camp was again very good, but the shooting of the inside men was again lamentably weak. Rhys-Evans in goal saved a number of awkward shots and always cleared well, whi st the defence, as a whole, did well to prevent Thomas's clever forwards from scoring more goals.

The replay of this match took place on our opponents' ground, at Chiswick, on Wednesday, March 23rd. Thomas's made one change, whilst Guy's had the same team out.

The ground was in perfect condition, and with the ball very lively a fast game resulted. As in the previous match, play was very even throughout, and up to half-time there was no score.

In the second half Guy's had a little more of the play, but never looked like scoring, and as Thomas's forwards were prevented from getting dangerously near Guy's goal, Rhys-Evans was able to cope with any shots that came his way. Time arrived with the score, 0—0.

It was again decided to play a quarter of an hour extra each way, and at about ten minutes from the restart Thomas's scored what proved to be the only goal of the match. Guy's after this tried all they knew to equalise, but were unsuccessful, so had to acknowledge defeat after putting up a good fight in both matches. Result:—Thomas's, 1; Guy's, 0.

Remarks.—A very fast game, and a good one. Thomas's forwards were very clever, and their backs and halves were very sound. It was only the more determined play of the Guy's team as a whole that prevented a bigger margin of goals. Camp was the pick of the forwards, and came very near to scoring on more than one occasion. Neal was safe at back, and Golledge fed his forwards well. Scarcely a man came off the field at the end without limping.

Cross Country.

The Inter-Hospital Challenge Cup.

The annual race for the Kent-Hughes Challenge Cup took place on Saturday, March 19th, from the Blackheath Harriers' Headquarters, the course being about seven miles. Guy's were the holders of the cup, but the London men turned up in great force to try and regain the cup which they had lost the previous year. Thanks to the fine running of J. R. Barrow-Clough and A. P. L. Johnson, we were able once more to hold the cup, the score being Guy's 18 points, London 45 (on the University system). The following was the order of finishing:—

1.	J. R. Barrow-Clough ...	Guy's.
2.	A. P. L. Johnson	"
3.	E. L. Hopkins	London.
4.	W. K. Fry	Guy's.
5.	W. E. Levinson	"
6.	F. S. Adams	"
7.	W. A. Bulleid	"
8.	C. J. Henry	"
9.	P. P. Boulter	London.
10.	J. R. Snelling	"
11.	W. H. Alderton	"
12.	H. C. Billing	"

Also ran, J. Benson, H. Neame, J. Mullan, and D. Lewis, all of London Hospital.

Change of Address.

Captain R. Tilbury Brown, R.A.M.C., from Colchester, to Rangoon, Burma.

Captain Brooke Churchill, R.A.M.C., from Bhamo, Burma, to Meiktila, Burma.

G. E. Wood, L.D.S., from Royal Naval Barracks, Shotley, to Royal Naval Barracks, Portsmouth (Dental Room).

(The Editor will be very glad to receive a postcard with notes of any change of address.)

Pass List.

University of London, March, 1910.

Second Examination for Medical Degrees, Part II.

T. I. Bennett.	H. C. Rook.
S. Keith.	A. L. Shearwood.
†G. S. Miller.	P. Smith.
J. Fred G. Richards.	H. Webb.
W. Robinson.	O. R. L. Wilson.

† Distinguished in Physiology.

University of Cambridge, March, 1910.

Degree of M.B. Conferred.

H. L. Duke, Caius.

Papers by Guy's Men.

Forsyth, David, M.D., D.Sc.: The Mind of a Child.—*Charing Cross Hospital Gazette*, March, 1910.

Birth.

FELTON.—On March 20th, 1910, at "Cartref," Etherow Bank, Broadbottom, near Manchester, the wife of Richard Felton, M.B., B.S. Lond. (late Sister Rennie), of a daughter.

Ed.—A. N. C.

GUY'S HOSPITAL GAZETTE.

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Passim.

IN our first issue in January of this year we reminded our readers that it was the year for the Biennial Dinner. We now hear that Friday, July 1st, is the date which has been fixed for that festive gathering to take place, and we hope that old Guy's men will write this date down in their note-books with a firm determination, not only to come themselves, but to induce as many as possible of their friends to do likewise, as upon their cordial help the whole success of the dinner depends. Last year an experiment was made: there were no speeches, the dinner ticket was fixed at 10s. 6d. (exclusive of wine), and the diners were arranged in groups at small tables, with a vice-chairman at the head of each table. We understand that, as the meeting in 1908 was so successful, the committee have decided to repeat the experiment in 1910, and in our next issue we shall publish a list of those who have agreed to act as vice-chairmen. We hope that the dreams of the committee may be realised, that the dinner of this year may be a greater success than last year in bringing together a record number of old Guy's men, and in affording them an opportunity for seeing and talking to old friends whom they rarely see on other occasions, in renewing old friendships, and perchance, too—for the younger generation, at any rate—in forming new ones. The splendid Connaught Rooms, Freemasons' Hall, Great Queen Street, W.C., have been chosen as the place of meeting.

BESIDES the Biennial Dinner, we have been asked to call attention to a number of functions of the same character which are to take place in the near future.

THE Goblins' Club is to hold its annual meeting and dinner on Thursday, May 5th, at the Café Royal, Regent Street. The Vice-President, Dr. E. I. Spriggs, will take the chair at 7 p.m. Members who wish to attend the dinner should send word to Mr. P. F. Henry, 79, King William Street, E.C.

THE Junior Guyite Club will meet for its annual dinner at the Restaurant Frascati, Oxford Street, on Thursday, May 12th, at 7.30 for 7.45. President: Charles Sangster, Esq.; Vice-President: H. G. Ashwell, Esq. Thirty-two members were present at last year's dinner, presided over by Mr. L. E. W. Stephens, and fourteen new members were elected. We would remind members that, by a recent alteration in the rules, they are entitled to bring as

guests to the dinner any Guy's man who is not a member. Communications concerning the Junior Guyite Club should be addressed to its Hon. Sec., Mr. J. A. Fraser, Western Lodge, Romford.

We wish to call particular attention to the first annual dinner of the University of London Officers' Training Corps, which will be held at the Victoria Restaurant, Victoria Station, on Wednesday, May 18th, 1910, at 7.30 p.m., and will be followed by a smoking concert. The Corps will be on parade in the afternoon at the University. All Guy's men who are members of the Corps are requested to attend, and so help to ensure the success of this function. Uniform must be worn. Tickets, price 4/6 (exclusive of wine), may be obtained from C. Gatley, H. C. Rook, and W. Robinson, and all applications should be made at once. Any Guy's men who are not members of the Corps, and wish to be present, should hand their names in to W. Robinson.

A number of common-sense suggestions are made by the Departmental Committee appointed to inquire into matters concerning coroners and coroners' inquests, in their recently-issued second report. We can only refer here to a few of the points raised. One paragraph, as it refers to a subject lately mentioned in these columns, in which the residents of hospitals take a very natural interest, we may quote in full. It refers to the absurd anomaly by which hospital house-officers receive a fee for attending inquests on B.I.D.'s, but not on persons dying in the institution itself. The committee remarks:—

> "We have been unable to obtain from anyone who has appeared before us a defence of this provision on its merits. In the case, at any rate, of the London hospitals, not only the visiting staff, but also the house-physicians and surgeons, give their services to the hospital without remuneration. We fail to see why a man who gives his services out of charity should be penalised for so doing by being required to perform a public duty, wholly outside the objects of the charity, without receiving the fee paid to other persons performing the same public duty. In all other courts a medical witness gets costs according to the scale, irrespective of the fact that he may be attached to an institution of a charitable or quasi-charitable nature. We think that this inequitable provision in section 22 of the Coroners Act, 1887, ought to be repealed, and, whatever may have been the original motives of policy for placing officers of medical institutions in a separate class and debarring them from receiving the fees payable to any other medical practitioner, we cannot see any reason whatever at the present time for continuing to deprive them of fees."

Among other suggestions, the committee recommends payment of coroners by salary instead of by a fixed sum per inquest; compulsory retirement of coroners at the age of 65; power to order a post-mortem examination without an inquest; abolition of the verdict of "felo de se." As examples of extraordinary verdicts of juries which coroners have, under the existing law, been compelled to accept, the report instances the following:—

> "The man died from stone in the kidney, which stone he swallowed while lying on a gravel path in a state of drunkenness."
>
> "A child three months old found dead, but no evidence to show whether born alive."

The question of deaths under anæsthetics has been made the subject of a special report. It is pointed out that there has been a steady progressive annual increase in the number of fatal accidents with anæsthetics since 1866, a larger increase, in the opinion of the committee, than can be accounted for by the increased scope of surgery which has developed during that time. Their reasons for this opinion are not, however, stated. For the future, it is recommended that every death under an anæsthetic should be reported to the coroner, who, after inquiry, should determine whether it is desirable to hold an inquest or not; that the administration of general anæsthetics should be restricted to medical and dental practitioners, and that the latter should be confined to the use of nitrous oxide; and that in the case of any death under an anæsthetic in a hospital or other similar public institution, there should be a scientific investigation into the actual cause of death, conducted by the authorities of the institution. In this connection, we may remind our readers that a summary of the cases of death during anæsthesia which occurred during last year at Guy's has recently been published in these pages.

While on the subject of anæsthetics, it is interesting to note an American opinion of English anæsthetists which may be found in a very valuable and entertaining article by Professor Wesley Mills, of McGill University, in the *British Medical Journal* for March 19th. The article is called "Some considerations bearing on the Surgeon, the Patient, the Student and the Nurse," and is based largely on the writer's personal experiences as a prostate case, and should be read by everyone who comes into contact with patients. Professor Wesley Mills makes the somewhat surprising observation that "much of the administration of anæsthetics on the American continent, as compared with that in England as carried out by professional experts who give their whole time to this, seems to me in comparison barbarous." It is somewhat refreshing, after hearing so much of the superiority of our American cousins to ourselves in medical matters, to hear of this opinion on their anæsthetists.

On the subject of nurses and nursing, Professor Wesley Mills has much shrewd observation to record. He would exclude from the nursing profession three classes of women at least:—1. The tactless; 2. The rough-handed; and 3. The amorous. We are pleased to find him advocating the teaching of nursing as a definite part of the medical student's curriculum: "In my opinion," he says, "a medical man, in starting on his career, should not only *know* all a nurse does, and a great deal more, but be able to *do* all that she can do." Much more might well be quoted from this article if we had space, but we must refer our readers to the original source.

Papers by Guy's Men.

Percival P. Cole, M.B., B.Ch., F.R.C.S.: The Relation of the Parovarium to Cyst Formation (Illustrated).—*British Medical Journal*, 26th March, 1910.

W. Sampson Handley, M.S. Lond., F.R.C.S. Eng.: Hunterian Lectures (Abstract of the) on the Surgery of the Lymphatic System. Lecture I.—*The Lancet*, 9th April, 1910.

Thomas Holmes, M.S., M.D. Lond.; Pelvic Hæmatoma of Ovarian Origin.—*British Medical Journal*, 19th March, 1910.

W. Bernard Secretan, M.B. Lond., F.R.C.S. Eng.: A Case of Gluteal Aneurysm. Transperitoneal Ligature of the Internal Iliac (Illustrated).—*British Medical Journal*, 2nd April, 1910.

Dental News.

In the Faculty of Medicine of the University of London the degree of Master of Surgery may henceforth be taken in Dental Surgery.

The examination will be open only to those who have taken the degree of M.B. and B.S. in the University. The first examination for the M.S. degree in Branch II. (Dental Surgery), will be held in December, 1910.

Candidates for the degree will be required to give four months' notice of their intention to enter for the examination.

The regulations are issued as follows:—

"Every candidate must forward, together with his form of entry, the following Certificates:—

1. A certificate of having spent at least three years in the study and practice of Dental Surgery at a teaching school or schools approved by the University, of which one year at least must have been subsequent to obtaining the M.B., B.S. degrees in this University.
2. A certificate of having held for at least six months an approved resident or non-resident appointment at a dental hospital.

Details of Examination. — The examination will consist of:—

a. One paper and *vivâ voce* examination in Oral Anatomy and Physiology and in Comparative Dental Anatomy.

b. One paper and *vivâ voce* examination in Oral Surgery and Therapeutics.

c. One paper and *vivâ voce* examination in Dental Metallurgy.

d. An essay on one of two subjects in Oral Surgery and Pathology.

e. One practical examination in Normal and Pathological Dental Histology.

f. One practical examination in Bacteriology.

g. A clinical and practical examination in Oral Surgery (including operative and prosthetic Dental Surgery).

Candidates shall not be approved by the Examiners unless they have shown a competent knowledge in all the subjects of the examination.

[Presentation of Theses, Publications of Pass Lists, &c., as for Branch I., except for the substitution of "Dental Surgery" for "Surgery" on page 170, line 5, of the Internal Regulations, and page 225, line 2, of the External Regulations.]

If in the opinion of the Examiners sufficient merit be evinced, a University Medal of the value of £20 will be awarded in Branch II. to the Candidate, whether Internal or External, who shall have passed with the greatest distinction."

A Short Account of a Trip to Kashmir, and a Visit to the Cave of Armanath.

By H. O. M. Beadnell, Capt. R.A.M.C.

At last the day arrived when we were free to set out for Kashmir and cooler climes, my leave having started, and very welcome it was after nearly four months' hot weather in old Mian Mir (now called Lahore Cantonment, as its previous name bore too unenviable a reputation), where on many a day the shade temperature ran at 110° to 115° F., and sometimes at 120°, and the nights—oh those nights!—at 90° or 94° all night long.

On July 24th, my wife and self, both of Guy's, and B—— of Dublin, caught the early morning train for Pindi; the journey was very trying, as the heat when the train stopped at every tiny station was intense. Every small station in India appears to be a hundred miles from anywhere, and yet every platform is a seething mass of perspiring native humanity, clothed in the flimsiest garments in every colour imaginable. The natives of India feel the intense heat very much more than is generally recognised, and a good many undoubtedly die from heat stroke. We reached Rawal Pindi in the dark and went to the Dâk Bungalow, pecuniary circumstances forbidding the more comfortable hotel. After somewhat frugal fare we retired to bed in the garden, the rooms being small and unbearably hot.

No sooner were we in bed than the jackals invaded the compound, making night hideous with their human-like shrieks.

At last they left us, and I thought "now we will get to sleep," when up rolled the entire troupe of a Cinematograph and Variety Show, who demanded food and drink in no uncertain voices with the good old Boro' accent: finally a cart, with the entire Bioscope plant in it, drove in at such a rate in the dark that the driver was on my bed before I could move, and I was sent flying, bed and all, into a flower bed; however, I picked myself up and returned to bed, reflecting in Christian spirit that it were better I should be thrown out of bed than my wife, but wishing it had been B——.

The "Artistes" only stopped to partake of food and drink and to pack up, and left again at about 3 a.m. to catch some train; all fast trains leave important stations in India at some unearthly hour.

Next morning, feeling very cheap, we were up at six, and loaded up our goods and chattels on three Ekkas.

Ekka carts are, as someone put it, like hansom cabs with both sides and driver's seat knocked out and replaced by rope. Two enormous wooden shafts which splay out sideways complete the structure. The harness is always a jumbled mass of string, rope and leather, and every mile or so the driver has to stop for repairs. The pony is generally as old as St. Paul's, and a mere anatomical study to hang the harness on.

No man has ever seen a young or even middle-aged Ekka pony. In spite of age, these ponies do wonderful journeys, anything up to sixty miles in the sixteen hours, the driver continuously urging them on by making a noise which, in any country but India, would mean that one wanted the beast to stop; but what can you expect in a country where even the robin wears his red feathers under his tail?

I may now state that it was our own mad intention to bike into Kashmir. The first day we biked half-way to Murree, reaching Tret at 4,000 feet, having, of course, walked it nearly all.

My wife soon tired of the game and turned the Khitmaghar out of his seat in the Ekka, the unfortunate fellow being able to ride a bicycle, though he did plead that he was not much good at shoving one. Next day we passed through Murree, the hill station for Pindi, and from here we had a fine run down of twenty-nine miles to Kohalla, where we slept the night. Here ended bicycling as far as my wife was concerned. In the morning we crossed the Jhelum river and were in Kashmir territory. From here onwards to Baramulla the road runs steadily uphill, and is a good ninety-eight miles tread-mill for bicycling. The road winds above the thundering torrent of the Jhelum all the way, through lovely scenery.

It took us three days to reach Baramulla, and it never stopped raining day and night, and the road, not too good at the best of times, was now deep in mud and water, and we were more like human sponges than human beings, and many a time I longed to throw my bicycle into the Jhelum.

B—— and I finally reached Baramulla at midday, wet through, and here at the Dâk Bungalow we sat enveloped in the only dry things we could find, namely, the curtains off the walls, while we waited for the Ekkas with our change of clothes, and they did not come until late at night. By evening time I had developed the finest acute synovitis in both knees, and was unable to put my feet to the ground for pain. That night we slept on the house-boat we had arranged to take from here, for from Baramulla the Jhelum river alters, and becomes wide and navigable for a hundred miles up stream to Islamabad, to which place we wanted to get. The house-boat we had had three rooms and large sliding windows, so that one could really live in the open air.

A second small "Dunga" we also hired for our servants and for cooking on. A "Dunga" is like a ferry boat, which has a house built on it of matting, and a thatched roof. The crew for both boats consisted of men and women, one family on each boat.

Next day we started up river, and obtained a distant view of Nanga Parbat, 26,400 feet—the fourth highest mountain in the world. For perfect peace and rest I know of no life to beat gliding up river in Kashmir on a house-boat, with green meadows and orchards on either hand, and a little further off the hills with the eternal snows on the higher peaks.

Some time the crew punt the boat, but they prefer to tow on a rope—then even the smallest child adds his four-year-old weight on to the rope, until, tired out, he mounts on to his father's shoulder, and from there, in a piping voice, directs the operations of the crew. We passed through the Wooler Lake, chiefly beautiful for its wonderful reflections and its mosquitoes, which, as B—— said, were so big you could hear them settling.

To get any peace at all, we had to anoint ourselves with paraffin oil, and we were glad to retire beneath nets that night. Two days after this we reached Srinagar, the capital of Kashmir. Our boat was instantly surrounded with crowds of small craft with anything and everything for sale, from Bromo paper to diamonds. "You come my shop, I sell cheap!"—"You see my chits, I honest man; other man proper thief. He been in jail. Only come my shop and see; only see, master, not buy." These were some of the hundred and one remarks shouted at us. One thing was clear, and that was that each man called any other man in the same line of business a liar and a thief: and here they spoke truth, as we realised to our cost before we left Kashmir.

I have not space to describe Srinagar, which has been visited by terrible fires, floods, and outbreaks of cholera; eye diseases seemed common among the inhabitants, and one eye, on an average, seemed to do duty for three of the poorer classes.

The main town is built on either side of the river, all the chief shops being visited by boat. Beautiful work of all kinds is for sale in the shops, and one would be tempted to spend a fortune there if one had it, and if one did spend a fortune one would be certain to have been swindled to the extent of a quarter of it. Any article on which you express doubts as to its genuineness, is always said to have come from Ladak or Yarkund; we hope to visit the former next year, where by all accounts the ground is strewn with precious stones. One peculiar brass kettle I bought, the man who sold it assured me it had come from Leh, the capital of Ladak, for did not he himself visit Ladak yearly, and had he not bought that very kettle for twenty rupees? He would sell it to the Sahib for fifteen rupees, as he wanted to please the Sahib and get good recommendation; finally I bought it for three rupees.

Next day another man came with similar kettles, a whole boat load of them; he, too, visited Ladak yearly, etc. I showed him my kettle—"Ah," he said, "man who sold you that is swindler—this made Srinagar, you come my boat, I show you where they making these."

Afterwards he owned that his goods, too, came from the same place in Srinagar. After three days' stay we left Srinagar and proceded on up river for three days to Islamabad, above which the river becomes too small for a house-boat. Here we hired coolies, and marched up the Lydda Valley. At Bawan we visited an interesting temple with a tank full of sacred fish, which we fed with special bread sold for the purpose. A Fakir here took our fancy, for he sat motionless by the water, but about once in five minutes he shook himself into energy and

A Fakir.

let forth a most appalling and terrifying buzz like an enormous hornet, only to once more subside into immobility amongst his rags and ashes. The Pundit here showed us a most interesting visitors' book in which we had to write our names. It dated back to 1827, and the names of many famous men were in it.

Lord Roberts' name appears in it as a Lieutenant, and later, again, as C. in C., India, with all his children's names. Curiously enough the first signature in the book is said to be that of a Russian. Near-by we visited the Cave of Bhomjoo, at the end of which, after travelling almost on all fours, we reached the place where a holy Fakir had spent the declining years of his life, all in a space six feet square; here he is said to have sat in total darkness for some years, the villagers bringing him food and laying it at his feet. Sure enough at this spot there lay a skeleton, but judging by its state of repair and odour, I do not think it had been there very long; perhaps as one skeleton wears out it is replaced by another, so that a source of backsheesh to the priests

may not be lost. Another cave near-by contained a most perfect stone Hindu temple; it was carved out of the solid rock of the cave itself.

Next day the scenery became grand, with its mountain torrents and rocks, and deodar and pencil cedar pines. In the evening we pitched camp at Pahlgam, in a big pine forest near the river. Here we spent a happy life in our little 80lb. tents, killing time in various ways. Fishing was good, all one wanted being hooks, string and a hedge stick, and we procured big baskets of snow trout.

The atmosphere in this part of the world is wonderfully clear, and distance very deceptive. One morning I set out to reach a snow-covered peak behind our camp, and it looked only a few hours off; by midday it appeared further off than ever, and I turned back home, reaching camp at dusk. Afterwards I found out that the peak was a good two days' march away. One day someone suggested our visiting the ice cave of Armanath, and hearing that it was a difficult road, and that but few ladies had ever seen it, we at once decided to go. Armanath cave is to the Hindu what Mecca is to the Moslem; and, yearly, pilgrims and Fakirs come from all parts of India to visit it, and do homage to Siva, the great Himalayan god, who lives in the cave in the form of a block of ice.

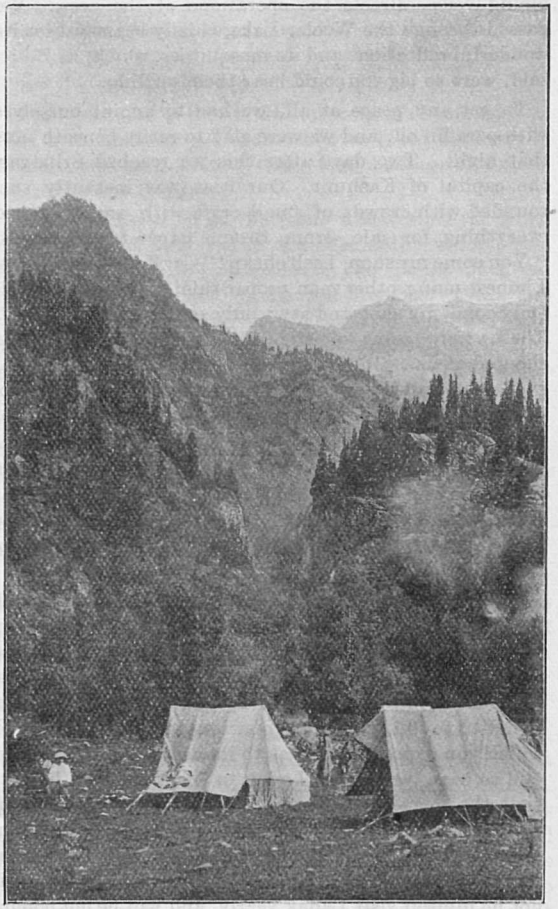
Towards the middle of August the Fakirs and pilgrims collect together near Srinagar, and then all march up to the cave together by stages, often numbering 6,000, and 2,000 coolies, a veritable army of Israel.

One of my coolies told me many weird tales about this pilgrimage, one being that the very holy Fakirs subsisted entirely on green grass during their long march of nearly one hundred miles. Later I saw all these Fakirs, and I must say they appeared to be doing themselves proud on something better than grass. When this enormous multitude reach a lake in the mountains called Shishra Nag they watch the sky with expectant eyes for a sign from the gods: if a bird flies across the lake it is a good omen (a bird is sure to fly across if they only wait long enough), and certain Fakirs then rush into the ice-cold waters of the lake.

Sometimes the sun is exceedingly trying, and then the pilgrims bind green leaves over their eyes to protect them from the glare.

We decided to leave part of our camp behind with as many things as we could possibly spare; these were to be left in charge of the old cook, aged close on eighty, whom I considered too old for such a trying march. On hearing my decision the poor old man was furious, insisting that he was hale, hearty, and in the prime of life; however, my wife quieted him down by saying we could not trust a mere boy like the bearer (aged thirty-eight) if left behind.

We could only travel very lightly, as the road was so bad for coolies, and we took not even beds. We set off early one morning with fourteen coolies and a pony for my wife, who had to ride straddle-wise, as no side-saddle was to be had. The coolies all protested loudly against their loads when they heard of our destination. Our first march took us to Tanin, at a height of 11,500 feet, and this camp we reached in a deluge of rain, the ground for tents being a lake. Our beds that night were on fir



Camp at Tanin.

branches, and we felt the cold intensely. Next day we passed the first snow bridge we had seen; this is really an avalanche of snow which has come down the mountain side and fallen across the river; the river quickly bores its way through the snow barrier and so leaves a bridge of great strength. On this day we only did about ten miles, and the going can be judged by the fact that it took us nearly nine hours. First we had a slippery ascent up a 1,000 feet sheer; it is called Pissu (a flea). The flowers we saw were simply lovely, blue being the predominating colour, big blue columbines, blue geraniums, big yellow sunflowers and poppies. One could only gasp in wonder at the wealth of colouring and all round the towering mountains with their snow caps and huge glaciers, many never trodden by foot of man. That night we camped on the shores of Shishra Nag Lake at an altitude of 12,000 feet, well above the tree line. Two

sahibs were in camp near by and had killed red and black bear.

No sooner had we pitched camp than a heavy storm burst on us and continued most of the night, but in spite of torrents of rain and no fuel except Juniper shrubs, our servants, with the aid of an umbrella as shelter, cooked us a most savoury and steaming-hot Irish stew. The coolies all spent the night in a hole under a rock huddled up together, sitting room only. As I went to bed I looked out through the fly of my tent; the lightning was continuous, and as it alternately lit up the lake, glacier, and snows, it made a sight never to be forgotten.

During the night we were all awakened by a rumbling and roaring noise, which afterwards we found was due to an avalanche coming down the opposite mountain side.

Next day we had breakfast in a thick white mist by the warmth of a big bonfire of our Juniper beds. After a fearful climb we reached the Panjitarni Pass at 14,000ft. Never having been at a high altitude before, B—— and I felt it badly, and could only go a few yards at a time and then sat down and gasped.

From the top of the Pass we obtained a striking view, and the rugged cruel-looking mountain of Armanath stood out in front of us so precipitous that not even snow could lie on it. From the top of the Pass we continued on down an easy descent to our last camping ground, Panjitarni. Here we were all much startled by suddenly hearing on the lonely hillside a noise like a police whistle, promptly answered by another further off, and then another; for a time we could not make it out, and then we suddenly spotted the cause—namely, Marmots; they sit up on their hind legs with their guinea-pig-like faces, and shriek out their warning whistle to each other. We watched them for some time; often one could see them place their paws on their abdomen, and apparently press inwards to get a louder note. We tried to pot one with a revolver, but as soon as you lift your hand they pop down their holes.

That night we were lucky in being able to purchase juniper for fuel from a shepherd, who had been collecting it ready for the pilgrims who were expected in a few days. The only bedding we could get was dock leaves; nevertheless, with a good hole scraped in the ground for one's hips, and a deep layer of docks, we slept the sleep of the just. The cold was so intense that no one attempted to get out of his clothes or even wash, I am sorry to say.

On this camp is a big mound of rocks, about 20 feet high, with rough steps up it, and on the top of this, as the pilgrims reach their last camp, sits the head Fakir beating a big drum.

Next day the coolies nearly all remained in camp, and we set out for the cave. The journey we knew was going to be real bad, so my wife on my advice had put on rational costume (mine!). For a short while we were unable to proceed, the servants and tiffin basket coolie being completely paralysed by the sight of a mem sahib in knickers. First we had to ford a river, as the bridge had been carried away by the last flood. The water was up to our waists, and as it came from a glacier we were nearly numb when we reached the other side. Here the pony had to be left behind, as it could not get along the track any further, and we climbed up a giddy zigzag path to 14,000 feet, and then there at our feet lay the Valley of Armanath, and for real desolation commend me to that valley.

The path twisted down to the valley bed, and here the path was over frozen snow, and under the snow one could hear the mountain torrent roaring. Another mile or two up this valley we had to go on this snow roof, and fearsome we were lest we might go through into the river, for large cracks appeared here and there.

At last the cave appeared in sight, with its big square entrance in the gypsum hillside, the entrance being roughly 150 feet high and wide; its length, too, is 150 feet. A last scramble over loose boulders and shale and we were in the cave.

The atmosphere in it was like that of an ice house, and the gloom depressing, and one could but glance nervously about for sight of the big black serpent said to live in the cave. At the further end of the cave is a large glistening block of blue ice, really a frozen spring, and this is Siva.

Our servants being Mahomedans had little respect for the great god of the Himalayan mountains, and were actually setting about breaking the ice up, as they said behind it was fabulous wealth, when we stopped them. The coolie filled his cloth with gypsum dust, as this, he said, he could sell to any Fakir who had been unable to visit the cave, at a good price. The Fakirs make it into a paste, and smear it all over their bodies and in their hair, and then, clothed in but a loin cloth, become a repulsive and rather terrifying sight. We were glad, after eating our lunch, to leave this depressing abode of Siva.

> Here never shines the sun, here nothing breeds,
> Unless the mighty owl or fatal raven,
> And when they showed me this abhorred pit,
> They told me here at dead hour of the night
> A thousand fiends, a thousand hissing snakes,
> Ten thousand swelling toads, as many urchins,
> Would make such fearful and confused cries
> As any mortal hearing it
> Would straight fall mad, or else die suddenly.

I should like to have seen the pilgrims arrive at this cave, for when they get in front of the entrance they raise a great shout to Siva to show himself, the Brahmins getting rid of all their clothes and using bits of birch bark as fig leaves. If some Rock pigeons fly out of the cave, then Siva has shown himself, for his spirit is in the body of a pigeon. Entering the cave the pilgrims throw their offerings in silver to Siva, and this I understand is very promptly pouched by Fakirs.

On our return route we crossed over a different pass called Aston Merg, and this was the highest altitude we reached, being over 15,000 feet. Unfortunately we crossed the pass in a dense white mist of clouds. The next two days we marched in pouring rain, and as we reached our camp at Pahlgam we passed the camp of

the pilgrims, thousands and thousands of them. Some had tents, others sat under umbrellas with blankets draped round them, making a kind of tent.

For the next fifteen days we had one continuous downpour day and night; I spoke to several pilgrims, Fakirs and police as they returned from Armanath; they had had a fearful time, and all estimated their dead at 150 from cold and exposure.

I felt even sorry for a Fakir, who, on the march up, had told me he would like to shove red hot embers in my eyes, because I had unwittingly trodden on ground that he considered his. We ourselves were, finally, simply washed out of our tents, and, with our bedding wet, clothes all wet, and supplies, even to tea, run out, we finally set out for Srinagar, which we reached in three days with infinite difficulty, as road bridges had been carried away, and the river was three or four miles wide in places, and so high that we could not even get a tiny boat we had hired under the bridges. It was a record flood.

I have written near Xmas time. May I conclude by wishing all Guy's men and women a very happy Christmas. We old Guy's people out here look back to Guy's days in our thoughts, with much longing, especially at this *the* season of the year—those best of days, never to return to us again.

16th December, 1909.

Correspondence.

To the Editor of Guy's Hospital Gazette.

Hancock Memorial Fund.

Dear Sir,—In answer to the letter which appeared in your issue of February 19th, subscriptions amounting to £5 5s. have been received by Mr. F. J. Steward and myself. I shall be glad if intending subscribers will communicate with us soon, so that the fund may be closed at an early date. I need not recapitulate the objects of the memorial, which were stated in my former letter, and would only remind those who wish to contri, bute that the subscription is limited to 10s.—I am yours truly,

3, Devonshire Place, Portland Place, W. C. H. FAGGE.

The Pageant of Empire.

Dear Sir,—On Wednesday the Hon. Secretaries of the London Pageant to be held at the Crystal Palace, on May 23rd, invited representatives from the different London hospitals to meet them.

It was then put to the representatives that students from the London Medical Schools should supply the performers in one of the scenes. It is specially appropriate that medical students should take some part in the Pageant, as the profits of the undertaking are to be handed over to King Edward's Hospital Fund. Three hundred men altogether would be required; most of these would be citizens, some on horse and some on foot, and there would be a few special parts, such as Wat Tyler, Dick Whittington, King Richard, and so on. While the Pageant is going on those who take part in it will have free admission to the Crystal Palace, and fares will be reduced to 2d. Refreshments at the Crystal Palace will be provided at much reduced rates.

The performances will take place on Tuesdays at 5 p.m., and Fridays at 9 p.m. Guy's Hospital is usually to the front, and it is expected that Guy's will be to the front on this occasion, too. A large number of men have already expressed a desire to take part. Will those who wish to take part give their names as soon as possible to Messrs. Mullins, Saner, Pryce Davies, Steinbach, Peall, Philip Smith, Gatley, Townrow, or

C. H. RIPPMANN.

Nursing News.

Matron's Office.

Miss Evelyn Windemer, who has been Sister-in-Charge of Bright Ward since October, 1906, left the Hospital on April 2nd to take up the appointment of School Nurse under the London County Council.

On April 1st, Nurse A. M. Ward, who has been Staff Nurse in the Isolation Wards since June last, was transferred to the Electrical and Light Department, and Nurse M. Fraser, who completed her training in February, was appointed Staff Nurse in Isolation Wards.

On April 1st, Nurse Ballance, Head Nurse in the Massage Department, was transferred to Bright Ward, and Nurse Forsaith, who completed her training last month, was appointed Staff Nurse in the Massage Department.

On April 2nd, Probationer Kinsman was appointed Head Nurse in Charity Ward.

Nurse O. Clifford left the Hospital on completion of her three years' training, and Probationer F. Ford was appointed to succeed her as Head Nurse in the Surgery.

On April 6th, Probationer Campion was appointed Head Nurse in Esther Ward.

On April 7th, Probationer Jones was appointed Head Nurse in Luke Ward.

On April 12th, Nurse Hepburn, Head Nurse in Naaman Ward, and Nurse Vanes, Head Nurse in Patience Ward, left the Hospital on completion of their three years' training. Probationer Spencely has been appointed Head Nurse in Patience Ward.

The following Nurses and Probationers have been successful in passing the Examination in Materia Medica and Pharmacy. Nurses: Jones, Lowe, Latcham, May, Skinner, Turner, L., Vine, and C. Wallis. Probationers: Balkwill, Blenkarn, M., Brereton, Boniface, Calvert, Clarke, Collett, Cox, Dickson, Dowley, Drew, E. Foster, Fyson, Garnett, Goddard, Gooderham, Grant, Hinds, Holdsworth, Hutton, Iles, Illingworth, Jolliffe, Keeble, Kirkham, Kirby, Lustic, Matthews, Maughan, Middleton, R. Miller, Moriarty, New, C. Orchard, Owen, C. Prince, Roussiano, Schlagentweit, Scott, Shepherd, Sime, Stevens, Stewart, Taylor, Tilleard, Todd, C. A. Ward, Waters, Windemer, Yates.

The Treatment of Corneal Ulcers.

CLINICAL LECTURE BY Mr. ORMOND.

Gentlemen,—You will find later on in your practice that this subject will give you considerable thought and anxiety, for, having diagnosed the condition, it is a matter of the supremest importance for you to employ treatment which will produce healing in the shortest possible time. All ulceration of the cornea which involves the substantia propria results in a permanent impairment of its transparency, and when you remember the smallness of the structure involved you will realise that a mistake in the matter of treatment may lead to very serious consequences.

Before commencing treatment, it is absolutely essential that your examination shall have been thorough, because there is an appropriate treatment for many of the various ulcers, and you must recognise the class of ulcer before you can possibly carry out its proper treatment; as, for instance, it is useless to attempt to treat a Dendritic or a Mooren's ulcer with simple ointments and lotions. You will find a good light invaluable for your inspection, and if the photophobia is extreme a drop of a 10 per cent. solution of cocaine will help to relieve some of the blepharospasm. Except for this use, however, cocaine is a drug which is contra-indicated in corneal ulceration. Another solution which you will find very useful in aiding you to ascertain the position and extent of the involved area is an alkaline solution of fluorescine; this substance has in alkaline solutions a bright green colour. A drop of it placed inside the conjunctival sac rapidly spreads over the whole conjunctival and corneal surfaces; the result of closing the lids is to squeegee the fluid over the unbroken corneal surface, so that the cornea itself, when the epithelium is intact, remains unstained, but wherever there is any depression, as where the epithelium is absent, the stain remains in the depression, and in that way, in the space of about a minute or so, the whole of the area denuded of its epithelium is coloured a bright green. This shows very strikingly in contrast with the darker background, and is especially marked if there is at the time some slight lachrymation. Having then ascertained the position and size of the ulcer, it is necessary to note its colour and the degree of opacity surrounding it. The more marked and definite the area of greyness surrounding the ulcer, the more septic is its nature; it is particularly important to notice how far the grey infiltration extends beyond the area stained with fluorescine, because that will give you some indication of the extent to which the corneal tissue proper is infiltrated. Further, the presence or absence of hypopyon should be noticed, and another important point is the undermining of the edge of the ulcer.

The successful treatment of corneal ulcers depends, as indeed it does in most other ulcers, upon our ability to remove the cause; that is to say, an ulcer caused by a foreign body will, after the foreign body has been removed, heal rapidly. Also, of course, an ulcer due to an inverted eyelash, a scratch, or other injury which is not continuously operating and has been remedied, will not give you any cause for anxiety, provided secondary infection has not taken place. The use of the word infection in the previous sentence reminds me that in all cases of corneal ulcer you should make it a routine practice to inspect the lachrymal sac, and by pressing over the inner canthus ascertain whether or no there is any purulent discharge from the lachrymal canaliculi.

Treatment of a simple uncomplicated corneal ulcer.—First and foremost, all discharge should be removed from the conjunctival sac by freely irrigating with warm lotions; this can under no circumstances be as effectively done by the patient himself as by some other person, and although we are compelled by circumstances frequently to trust to a series of bathings with an eye bath or other means carried out by the patient himself, nevertheless you should on all occasions, where possible, wash out the conjunctival sac yourself. The patient should be placed on a table or couch and lie on his back. Mix the lotion with an equal quantity of warm water in a clean basin or tea-cup and soak some pieces of cotton-wool or clean rag in it. (More convenient to use, but not always at hand, is an Undine.) Stand behind the patient's head and with the thumb and finger of one hand gently separate the lids as far as possible, without hurting the patient. Take the soaked wool in the other hand and, holding it above the eye, squeeze the wool so that the lotion runs in between the parted lids. Continue the washing until no more discharge comes away and the lotion runs clear. If ointment has been ordered, draw down the lower lid, and put a small piece over the edge of it.

To put drops in the eye, a bottle fitted with a glass tube (or pipette fitted with an india-rubber

teat) is necessary. Hold the bottle, tube downwards, in the hand, directly over the everted lower lid, and direct the patient to look upwards towards his brow. The warmth of the hand will cause a drop to fall within the lower lid. The bottle must not be full; there must be some air in it. Having thoroughly washed out the conjunctival sac, a drop of atropine solution should be used, and a little iodoform insufflated. Photophobia is frequently a distressing symptom, especially with children; this should not be allowed to continue untreated, but, as far as possible, the eyes should be protected from light either by a large shield or dark protecting glasses. The shield can be easily made by cutting a piece of cardboard into a ⌂ shape, attaching a piece of tape to its two ends and covering the cardboard with some dark material. The patient should on no account be allowed to keep his eyelids firmly screwed up, and if the photophobia is very extreme, canthotomy should be performed; that is, dividing the orbicularis palpebrarum at the outer canthus, and so diminishing its sphincter action. If the patient suffers great pain, we have a very useful drug in dionine; this is an analgesic, and it may be mixed with iodoform and used as an insufflation, or it may be dissolved with the atropine; an ointment is sometimes, however, more convenient. I would recommend the following: dionine, xx. grs.; iodoform, xx. grs.; atropine sulphate, iv. grs.; vaseline to ʒi. Leeches have become unfashionable, but where the pain and congestion of the eye are considerable a couple of leeches applied to the temple often act as a charm; and blisters also are useful as counter-irritants.

With regard to the expediency of using a bandage, that must be settled by the amount of discharge present and the condition of the corneal epithelium; if the discharge is considerable the eye should not be tied up; on the other hand, a bandage keeps the lids at rest and helps to support the inflamed and softened cornea, so preventing the newly-formed epithelium from being rucked up by the lids, and also it aids in lessening any distortion of the cornea, resulting from a yielding of the softened inflamed structure to the intra-ocular tension. Constitutional treatment should always be employed, a brisk purgative administered early, and regular attention to the action of the bowels should be insisted upon; tonics and, in phlyctenular cases, cod liver oil should be given. The compound syrup of the phosphate of iron or the syrup of the iodide of iron are very useful medicines in these cases. The patient should be kept in the fresh air as much as possible; diet should be plentiful, and alcohol is not contra-indicated unless the eye is very congested or iritis is present. Sometimes great mental depression ensues, and this will require attention; the patient should be kept interested and amused as much as possible by being read to, etc. Where the patient is a very young child who might insist upon pulling off all its bandages, it is well to keep the arms in splints.

Let us now pass on and consider some of the special ulcers which require particular treatment.

Serpiginous ulcer with hypopyon.— A large percentage of these ulcers are infected by organisms derived from a suppurating lachrymal sac, a number of them being due to the pneumococcus; you must therefore carefully examine the lachrymal apparatus in order to ascertain if that is the source of infection, and if so, the lachrymal sac should be at once removed; on the other hand, where the source of infection is to be found elsewhere, the ulcer must be treated directly. In these ulcers the organisms producing suppuration are in the *substance* of the corneal tissue itself, and their position is marked by a sinuous grey line, which can usually be seen extending beyond the ulcerated area. Now the application of ointments and lotions to the conjunctival sac will obviously not reach these: it is necessary to "dig down" into the corneal tissue, and so "throw out" the offending organisms. The best way of doing this is by means of the galvano cautery. The conjunctival sac should be washed out and a few drops of solution of cocaine, 10 gr. to 1 oz., should be applied, the lids being kept apart by a speculum. The needle of the cautery should be of a dull red heat and applied over the whole of the ulcer and beyond its edge into the clear area of the unaffected cornea.

It is advisable to avoid perforating the cornea, and the main object in applying the cautery should be first of all to destroy as far as possible the micro-organisms lying deep in the cornea; secondly, the removal of dead material at the base of the ulcer, and also to provide a channel of escape for the inflammatory products present in the substance of the tissues. Unless the growing edge is destroyed, you will find in a few days that the infection has spread into that part of the cornea which is now clear, and wherever this takes place the corneal tissue will be destroyed and a dense scar result. It is unwise to limit the use of the cautery to the actual ulcerated

surface, because it is almost certain that this will fail to stop the progress of the invasion, and although it is true that a scar will result wherever the cautery is used, yet the scar will be no larger, in fact not so large as would result if the ulcer should still spread on, and of course it is possible that if left alone the ulcer would destroy the whole cornea. During the few days subsequent to the use of the cautery the eschar is thrown off, and if no further extension takes place the ulcer may be treated as a simple ulcer, but it will take from six to eight weeks to heal; the hypopyon need not be interfered with; it always disappears as the ulcer heals. Another method of treating these ulcers was devised by Professor Saemisch, of Bonn, who advocated the making of an incision through the whole of the cornea, taking the densest part of the ulcer for the line of the incision; by this means free exit is obtained for the micro-organisms and inflammatory products, since the whole thickness of the cornea is cut through. Professor Saemisch suggested the incision being made horizontally, but Mr. Higgens always made his vertically, a method which minimises the risk of prolapse of the iris.

Sloughy ulcer.—If the ulcer is large and suppurating, but the edges not deeply undermined, the organism can be reached directly from the front; it is then sometimes sufficient to scrape away the sloughy tissue from the surface of the ulcers and apply pure carbolic acid to the ulcerated area. Pure carbolic has many advantages; it is of course a powerful antiseptic and an analgesic, but in addition it is soluble, so that its use is not attended with much pain, and the scar is not increased by its application. I find it very useful in infected ulcers, and I sometimes use it in cases where the cautery seems to offer too drastic a remedy.

Quinine has been very highly recommended in cases of sloughy ulcers, and in large infiltrated and infected ulcers without undermining, quinine is very useful. It should be prescribed as drops and lotion in the strength of four grains to the ounce, and used four times a day with an eye bath, so that the solution is kept applied to the corneal surface for five minutes at a time.

Dendritic ulcers.—This form of ulcer is characterised by being essentially superficial and of little density, with a tendency to spread by branching. It is generally seen to come from the margin of the cornea, across the pupillary area, sometimes reaching the opposite side from that from whence it came. It is a kind of herpes affecting the cornea, and the lesion is probably connected with the nerve terminals in the epithelium. Now in treating these dendritic ulcers, it is essential to apply your remedy below, that is, deep to the epithelium. Cocanise the eye, and vigorously rub over the surface of the cornea a small pledget of wool soaked in absolute alcohol, so as to remove the epithelium from the substantia propria. By this means I have sometimes succeeded in curing one of these ulcers in three days. If, however, the condition has not been recognised early, secondary infection may have taken place, and then one application of the alcohol may not be sufficient, and the treatment will have to be repeated two or even three times.

Some patients show a marked susceptibility to the effect of atropine, a violent dermatitis resulting at once from its application. In such cases, Homatropine, iv. grs. ad ʒi.; Scopolamine, ii. grs. ad ʒi.; Duboisine, ii. grs. ad ʒi., or Euphthalmine, iv. grs. ad ʒi., may be substituted. In phlyctenular ulcers very finely powdered calomel insufflated into the conjunctival sac acts beneficially in two ways; the mechanical irritation of the powder stimulates the conjunctiva, and so improves the circulation in it, and the powder remains in the conjunctival space and is slowly absorbed, the result being that the eye is constantly bathed with an antiseptic lotion. Finely-powdered iodoform may be used instead of calomel in sloughy ulcers, and acts excellently.

Treatment of the resultant scar.—I have already said that when any of the substantia propria of the cornea itself is destroyed, the membrane is replaced by opaque scar tissue. Corneal scars can be treated with very gratifying results if only the treatment be started early and continued for months or even years, and the younger the patient the more hopeful the result.

The principle of treatment is this: some of the opacity is due to inflammatory products which are capable of being absorbed, and we aim at increasing the lymph circulation through the cornea, and the vascular circulation of the conjunctiva and sclerotic. For this purpose mildly irritating ointments and drops and lotions may be used, as ung. hyd. ox. flav.; guttæ cupri sulph., ii. grs. ad ʒi.; guttæ zinci sulph., grs. ii. ad ʒi., and dionine 5–10 per cent. When employed locally, dionine causes an intense hyperæmia and œdema of the conjunctiva with some tingling pain and lachrymation, and results in a marked improvement in the absorptive powers of the lymphatics.

Sub-conjunctival injections of salt solutions 5–10 per cent.; perchloride of mercury 1–1000; cyanide of mercury 1–5000, the latter in doses

of 2–4 minims, have been highly recommended, but I am not convinced that they act any better than other remedies which are safer and easier of application.

It is a good thing to use one remedy, say for one month, and then change to another, and later on to a third, as the tissues seem to become accustomed to a drug and react more vigorously when it is first applied than later.

Pass List.

University of London, March, 1910.

Second Examination for Medical Degrees, Part I.

F. V. Bevan-Brown.	A. C. Hancock.
F. C. S. Broome.	*S. S. B. Harrison.
F. Collar.	M. D. McManus.
W. L. G. Davies.	A. N. Minns.
F. H. Dodd.	J. Y. Moore.
H. W. Evans.	L. Muir Smith.
*C. H. Gould.	J. Stephenson.

* Awarded a mark of distinction.

First Conjoint Examination.

March and April, 1910.

Parts I. and II.—Chemistry and Physics.

*P. R. Chevreau.	*N. H. S. Maelzar.
S. W. Coffin.	†H. Millett.
†H. C. Duggan.	A. F. Rook.
*D. V. Halstead.	*N. H. W. Saw.
F. E. R. Laborda.	

* Passed in Part I. only. † Passed in Part II. only.

Part III.—Elementary Biology.

C. de Wet Gibb.	W. G. S. Neely.
A. H. H. Harkness.	R. Quesada-Jimenes.
R. A. Holmes.	N. H. W. Saw.
F. E. R. Laborda.	R. C. W. Staley.

Royal College of Surgeons of England.

March and April, 1910.

Preliminary Science (L.D.S.) Examination.

W. A. Bulleid.	F. R. Wallis.
W. J. O'Kane.	F. Wisher.
E. R. Saul.	

University of Durham.

Second M.B.—Anatomy and Physiology.

H. G. Dodd.

Degrees of M.B. and B.S. Conferred.

B. G. H. Connolly.

Stanley Hodgson, M.D., B.S. Lond., M.R.C.S., L.R.C.P., of the Inner Temple, London, was placed second in honours in the Final Examination for Certificate prior to Call to the Bar.

Residents' Dance.

The Annual Dance of the Residents was held at the Wharncliffe Rooms, Great Central Hotel, on the 31st March, and proved a highly enjoyable function. No doubt the fact that the dance followed so soon after Easter rather mitigated against a record attendance, nevertheless we congratulate the Residents on their success. The arrangements were all that could be desired, the excellence of the floor and the supper, served in the Great Central's magnificent dining hall, came in for no small measure of praise.

The orchestra rendered a selection of dance music, on the choice of which we offer our heartiest felicitations to those responsible.

The Countess of Bective again kindly received on behalf of the Residents. Amongst the ladies present we noticed Lady Perry, The Matron, Mesdames Hale White, Eason, Fagge, French, Rowlands, Turner, and Shenton. The nursing staff was represented by twelve sisters. Amongst the gentlemen were seen, Dr. Hale White, Drs. Eason, French, Hertz, Rippmann, and Messrs. Fagge, Rowlands, Turner, Shenton, Aubrey, and several old Guy's men.

It is rather to be regretted that the junior men in the hospital do not patronise this function more. They should have no illusions as to its nature; it is thought by many of them to be essentially a senior men's dance. This is not so, as can be understood in a minute when one is told that the venue has been moved from the Court Room, where it was held for many years, with the idea of extending its scope. We trust that next year the attendance will break all previous records. To the Stewards thanks are due for the excellent manner in which they carried out their duties.

Appointments.

Civil.

Gater, H. J., L.M.S.S.A. Lond., L.M.R.C.P. Irel., has been appointed Clinical Assistant to St. Paul's Hospital for Skin and Genito-Urinary Diseases.

McDougall, J. T. M., M.R.C.S., L.R.C.P. Lond., has been appointed District Medical Officer of the Southampton Union.

Pakes, W. C. C., M.R.C.S., L.R.C.P. Lond., D.P.H. Camb., has been appointed Superintendent of the Leper Asylum, Orange River Colony, South Africa.

Webber, H. W., M.D., M.S. Lond., has been appointed to the Honorary Staff of the Didworthy Sanatorium.

Naval and Military.

Fleet-Surgeon A. E. Kelsey, R.N., has been placed on the retired list. His commissions are thus dated: Surgeon, Nov. 11th, 1891; Staff Surgeon, 11th Nov., 1899; and Fleet Surgeon, 11th Nov., 1907.

Staff-Surgeon E. S. Tuck, R.N., was appointed to the *Victorious*, March 31st.

Captain F. M. Ommanney, R.A.M.C., has been transferred from India to the Home Establishment.

The Aetiology and Pathology of Pigmentation in Constitutional Disease.

The Treasurer's Prize Essay.
Guy's Physical Society, 1910.

By Frank Cook, B.Sc.

II.—The Manifestations of the Pigments.

Pigmentation may be classified according to its localisation, according to the conditions under which it occurs, or according to the nature of the pigmentary deposit. The procedure already adopted suggests a selection of the latter course, a classification dependent on the elements involved; in this way clinical observations may best receive interpretation from the use of scientific facts. The disease itself becomes of secondary importance for the present, although an understanding of its every feature is our final aim. An attempt has therefore been made to select those diseases which best illustrate the processes of pigmentation rather than to exhaust the list of those which number pigmentation with their other symptoms. Exogenous pigmentations, such as accompany anthracosis and argyria, have been neglected.

As a preliminary to the discussion of pathological changes, it is necessary to provide as standards some account of normal pigmentation as displayed in different regions of the body. The physiological pigmentation of the skin in different people presents far greater variation than appears in any individual, whether he be in health or sickness; however swarthy the subject of Addison's disease, he never reaches that intense degree of pigmentation which the negro shows. There is a striking contrast between the skin of the negro and that of the Teuton; every intermediate grade of coloration may be found. The difference between white and black, blonde and brunette, is determined by the extent of cutaneous melanin formation; this in turn seems to depend upon the activity of the melanogenetic enzymes, for excess of the other factors tending towards an increased production influences the colour of a skin already dark more than that of one with lighter hue. Although we are dealing more particularly with relative than absolute amounts, it is of interest to note that the entire skin and hair of a negro contain not more than one gram of melanin, so intense is its staining power; pigmentary metabolism in general appears to be of a highly conservative nature. In white races the skin normally contains very little pigment, except in such regions as the areolæ mammæ, axilla, and scrotum, where an appreciable deposit of melanin exists. Such coloration as there is in other parts of the skin depends upon the lipochromes of the subcutaneous fat and the degree of vascularity rather than the presence of a cutaneous pigment.

The oral mucous membrane of the negro and negroid races has on occasion been observed to exhibit patches of pigment; this fact has been known to cause confusion in the diagnosis of disease.

The colour of the hair is partly due to a pigmentary deposit and partly to phenomena of purely physical character. The relative importance of these factors is a matter of uncertainty. Delépine attributed to the medulla of a hair the same power of secreting pigment as the basal layers of the rete Malpighii. Histologists now deny that the medulla contains pigment, and ascribe the appearance of coloration to its peculiar structure. The cortex is admitted to contain traces of material pigment, presumably melanin; but here, too, structural features seem to influence the colour. Of the nature of those substances or processes which give rise to the appearance of red or yellow hair we have no direct knowledge; these particular tints are said to be due to a diffuse coloration of the protoplasm of the hair cells, which is masked in black or brown hair by an excess of cortical melanin. But on the other hand it is more probable that they represent pigments like melanin in type, which result from an incomplete or perverted activity of the melanogenetic catylases in certain individuals, who, from other considerations, are known to be deficient in the formation of melanin proper. Like the brilliant and beautiful colours of the plumage of birds they may depend upon the existence of interference phenomena rather than material pigments. The greying of hair in elderly people follows a phagocytic removal of the cortical pigment, whilst the subsequent appearance of white hair is due to shrinkage and atrophy of the hair cells with corresponding increase of the intervening air spaces.

The colour of urine may, under physiological conditions, vary from the palest yellow to a reddish brown. Pathological processes may result in obvious variations wider still than these, yet an abnormal excretion of pigment may occur which is entirely unappreciable to the naked eye, though highly important as an indicator of metabolic or structural disturbance. In this direction the spectroscope has been of the greatest assistance, especially as the urinary pigments are so unstable and small in amount as to be difficult of isolation; but spectroscopic examination is by no means infallible, and our knowledge of urinary pigmentation is therefore incomplete. Normal urine owes its colour essentially to urochrome; it also contains traces of urobilin, hæmatoporphyrin, and uroerythrin.[5]

The pigmentation of the fæces depends upon the output of bile pigment into the intestine, and to a very slight extent upon the degree of absorption of urobilin.

Hæmoglobin is constantly being set free from the red corpuscles. In health, this liberation is brought about in the spleen and liver, and further changes are imposed by the latter organ before excretion in the bile or urine. But under certain conditions hæmoglobin is excreted by

5 Uroerythrin is a pigment to which no reference has yet been made. Its origin is doubtful, and even its structure is unknown; it appears as the colouring matter of pink urate deposits; although its tinctorial property is high, the quantity excreted is exceedingly small.

the kidney without change. This follows excessive destruction of erythrocytes, such as may be effected experimentally by injection of large quantities of water, glycerin, potassium chlorate, arseniuretted hydrogen, toluylenediamin or foreign serum. Hæmoglobinæmia is thus produced. In disease, hæmoglobinæmia is of frequent occurrence: a well-marked example is afforded by "post-mortem imbibition." This occurs more particularly in cases of general sepsis; circulating toxins promote hæmolysis which results in solution of hæmoglobin in the plasma with diffusion into surrounding tissues; the heart valves and aortic intima are stained and present a bright pink coloration. During life, hæmoglobinæmia is indicated by direct examination of the blood, or, where the intravascular breakdown is severe, by the appearance of hæmoglobin in the urine. The explanation usually given for this excretion by the kidneys is that the liver, unable to deal with an increase of pigment beyond a certain point, leaves untouched the excess of liberated hæmoglobin to circulate in the blood until excreted with the urine. But other considerations show that a profound degree of hæmo-hepatogenous jaundice would result long before the liver gave up its task of destruction. This is not a feature of hæmoglobinuria, though a slight degree of cutaneous coloration has been observed. We must therefore find some other explanation. A hypothesis based on anatomical grounds is not far to seek. Hæmoglobin is set free at different parts of the blood stream; circulating in the ordinary way, part reaches the renal influence direct, part reaches the liver; we may logically assume that the former is excreted as such, while the latter is excreted after conversion into bilirubin.

Hæmoglobinuria is caused by certain hæmolytic poisons such as those already mentioned, and particularly by potassium chlorate, certain poisonous mushrooms, and snake venoms. The pigment may appear in the form of methæmoglobin, as after potassium chlorate; this modification takes place more frequently in the bladder than in the blood stream. The coloration may be red or brownish red, sometimes quite black; when the hæmoglobin occurs only in small quantities it imparts a lake or smoky colour to the urine.

A remarkable condition known as paroxysmal hæmoglobinuria is characterised by the occasional passage of hæmoglobin in the urine. The pathology of this disease is somewhat vague It seems to be associated in some way with cold and exertion, and has a close relation with some forms of Raynaud's disease. MacAlister, in a comprehensive review, concludes that the blood of affected subjects contains a potential hæmolysin called into activity by those influences, particularly external cold, which are known to determine the onset of a paroxysm. These influences may operate directly or reflexly. Thus, external cold may directly chill the blood at or near the surface, or it may act indirectly by way of the nervous system, sending impulses along a path analogous to if not identical with the vaso-motor arc. Although the serum may be activated experimentally by the direct application of cold, it is more probable that the natural hæmolysis is brought about by reflex mechanism. There is no evidence, however, to suggest by what means the nerve endings in the vessel wall affect the blood itself. Neither is the ultimate source of the hæmolysin known. Syphilis is a possible antecedent in many cases, but others occur where syphilitic influence can be excluded. The disease involves a profound destruction of red cells, and although a paroxysm is attended by rapid reconstitution, repeated attacks seem to strain severely the formative powers of the individual and result in some degree of anæmia.

Hæmoglobinuria is also a feature of certain fevers and their sequelæ. Like syphilis, these may conceivably confer upon the subject a predisposition to paroxysmal hæmoglobinuria. Malaria has frequently been regarded as an antecedent of this order; yet there is no definite evidence in support of such a view; there seems to have been some confusion between hæmoglobinuria of the paroxysmal type and mild cases of black-water fever. Failing evidence to the contrary, it seems more reasonable to look upon the febrile toxins rather as hæmolytic agents themselves, similar in action to those poisons already cited, than precursors of a hypothetical hæmolysin. Malarial hæmoglobinuria appears to be essentially due to the direct influence of the hæmatazoon, though many observers attribute to quinine a large part in its causation.

Derivatives of hæmoglobin, apart from the bile pigments, give rise to an abnormal pigmentation of the skin in many morbid conditions. It is rarely possible to distinguish their individual presence or the preponderance of any particular pigment; it is indeed probable that all are represented in every case of pigmentation due to an increased disintegration of hæmoglobin. Where that disintegration is excessively severe, such quantities are brought to the liver as to cause a blockage of the bile channels by the bile pigments formed therefrom; these then regurgitate, and, in producing a condition of jaundice proper, mask the coloration effected by the prebiliary derivatives. This latter coloration does not, however, as is frequently supposed, necessarily indicate any sluggishness on the part of the liver in formation and excretion of bile pigment; it may be due to bodies which have not reached the hepatic influence, as in cases where an intravascular liberation of hæmoglobin is accompanied by diffusion into the tissues and some degree of dissociation. It is true that urobilin generally plays a part and figures side by side with hæmosiderin and the like; the presence of this body may certainly point to some impairment of hepatic function as has been suggested. This factor would afford partial explanation of many of those pigmentations to which diseases of the liver may give origin; yet the large quantities of hæmosiderin found in that organ post-mortem suggest some degree of incompetence in the manufacture of bile pigment with a possible damming back of the precursors.

Septicæmia and toxæmia give rise to the most pronounced pigmentations of purely disintegrative origin. Many of these cases are regarded as hæmo-hepatogenous

jaundice until after death, when the liver is found to be normal. The coloration of the skin fails to assume, however, that tinge of green which is characteristic of the presence of biliverdin, whilst examination of the urine should demonstrate the absence of those pigments which are essentially hepatic in origin. The wards of this hospital furnished an example of such a condition a few months ago. A patient was admitted whose general health was remarkably bad, and appearance "toxic" in the extreme. She had been ill for seven years, and had spent much of that time in bed. Four years before admission an operation for appendicitis had been performed, and a year later an operation for gastric ulcer; neither had afforded relief for any length of time. Shortly after entering the ward, colectomy was performed. For the following week all went well, but on the seventh day the patient suffered from intense abdominal pain, and on the next day she assumed a dark yellow coloration, which was regarded as jaundice at the time. This coloration increased in intensity until, three days later, death from general peritonitis supervened. On post-mortem examination, a large abscess was found in the abdominal wall. Whatever the possibility of previous auto-intoxication, it is clear that a maximum degree of toxæmia was reached before death. The liver was examined. To the naked eye it presented little or no abnormality; microscopic examination revealed no dilatation of the bile capillaries, and, except for an extremely slight excess of bile pigment, a normal structure in general. The pigmentation was therefore of an origin almost purely hæmatogenous, presumably due to a diffusion of hæmosiderin, hæmatoidin and urobilin into the tissues. The patient's appearance was undoubtedly free from greenish tinge, though the coloration was intense. Unfortunately the urine does not appear to have been examined after the onset of pigmentary symptoms. To compare this case with one of hæmohepatogenous jaundice toxic in origin, where the primary cause is the same and the effects alike, seems to reduce any clinical distinction to the form of a quibble. Yet there is a fundamental pathological difference which amply justifies the attempt to separate the two. It is regrettable that such a term as "jaundice" should be reserved in general for the obstructive types alone, whilst with equal right it applies to all.

Milder degrees of coloration are produced in a variety of diseases in which hæmolysis plays a part. It is a frequent feature of those conditions already described as giving rise to hæmoglobinuria, and may thus be exhibited in paroxysmal hæmoglobinuria, in malaria, and in various fevers—enteric, scarlatina, typhus, relapsing fever, etc.

Pernicious anæmia is a fairly constant cause of cutaneous pigmentation. The skin has generally a lemon-yellow tint, which is partly due to products of hæmolysis and partly to an abundance of lipochrome in the subcutaneous tissue. The coloration is occasionally so intense as to approximate that of jaundice, whilst in other cases it may resemble that of Addison's disease; the latter form usually follows the administration of arsenic, and would therefore appear to result from an increased formation of melanin in addition to the primary pigmentation. Abnormal pigmentary deposits have occasionally been observed in the buccal mucosa These, too, have been assigned to the influence of arsenic, but in one case at least buccal pigmentation has occurred previous to arsenical treatment.

The pathology of pernicious anæmia is indefinite. Increased hæmolysis may be the primary factor or, on the other hand, it may result from a defective hæmogenesis and abnormal vulnerability of the corpuscles. Hunter concluded that the hæmolysis was due to an alimentary intoxication. This, in turn, may depend upon an absorption of the products of abnormal bacterial fermentation, or the development of a state of subinfection from the presence in the digestive tract of organisms pathological in quantity or type. Should the disease have origin in an auto-intoxication of this nature, the accompanying pigmentation would necessarily assume a complex character from the number of factors involved. The immediate products of hæmolysis would represent the first of these factors, an excessive formation and absorption of urobilin a second; the latter would result from the hyperactivity of bacteria in the intestine. (A marked degree of urobilinuria has certainly been found in many cases of pernicious anæmia; yet this increase may be due to a more abundant supply of the precursors, bilirubin and bilverdin, rather than to an abnormal activity of the agencies at work, for the bile pigments are naturally augmented as a result of hæmolysis whatever its cause.) The pigments which appear to result from an increased formation of the aromatic antecedents of melanin might supply a further factor, and hence the occasional confusion with Addison's disease; these will be discussed in connections where the existence of intestinal intoxication is less doubtful. On the whole, evidence does not favour this theory of the origin of pernicious anæmia. The non-appearance of aromatic bodies in the urine is a definite contra-indication. If we accept the view that a defective hæmogenesis is the primary cause, we must regard the pigmentation as being due to the immediate derivatives of hæmoglobin alone, with urobilin formed from their increased disintegration. Internal organs such as the spleen, pancreas, intestines, and particularly the liver, show a content of hæmosiderin and other pigments far greater than that of the skin.

Large deposits of hæmosiderin and allied compounds may be found in the liver and other tissues in the condition known as hæmochromatosis. This again is quite distinct from jaundice, although it is probably hepatic in origin. The skin presents a dull brownish or bluish discoloration. Some observers have regarded hæmochromatosis as a definite and specific disease. Cirrhosis of the liver is a frequent accompaniment; this suggests an accumulation of prebiliary pigment and an interference with the circulation of urobilin as a result of decreased activity on the part of the hepatic cells. It is, however, extremely difficult to draw definite conclusions with

regard to the action of the liver in producing any condition of pigmentation. In many cases of cirrhosis, for instance pigmentation is due to a concomitant catarrhal jaundice, whilst in others it may be due to pressure on the bile ducts by contracting fibrous tissue and so to jaundice essentially obstructive in character. In Hanot's cirrhosis the type of coloration gives definite indication of a regurgitation of bile. Bronzed diabetes, on the contrary, presents a cutaneous pigmentation of quite different appearance. It has been shown by many observers to represent a deposition of hæmosiderin and hæmofuscin in the skin. This fact, together with the post-mortem characters of internal organs, renders bronzed diabetes a typical example of hæmochromatosis. The liver is cirrhotic, and to this circumstance the pigmentation is probably due. Diabetic xanthosis is generally regarded as a distinct manifestation; yet it appears to result from the same class of pigments, though different in appearance, and may prove to be an early stage of the bronzed variety. An increased excretion of urobilin in many cases of hepatic cirrhosis has some significance; however numerous the factors leading to urobilinuria, and however diverse the possible deductions therefrom, it is fairly certain that obstructive jaundice admits of no such increase.

Pigmentations due to bilirubin and biliverdin are next for consideration. These follow a regurgitation of the bile pigments from their normal channels into the blood and tissues of the body. In more than four-fifths of all cases of jaundice this regurgitation is due to an obstruction in the larger bile ducts. The obstruction generally results from a catarrhal inflammation of the ducts spreading from the duodenal walls, from the presence of gall-stones and other foreign bodies, from the pressure of enlarged glands in the portal fissure, from growths of the liver or head of the pancreas, and possibly from the constriction of fibrous tissue in hepatic cirrhosis. In other cases the regurgitation depends upon a blockage of the terminal bile capillaries rather than an obvious closure of the ducts. This may be due to an over-accumulation of viscid bile pigment, or to disease of the hepatic cells; these two factors often, though not necessarily, work hand in hand. The same toxic agent which gives rise to an increased breakdown of blood may poison the cells of the liver, causing them to swell up and discharge a sticky mucous in such a way as to occlude the terminal biliary channels. The jaundice of yellow fever, Weil's disease and acute yellow atrophy appears to arise more particularly from hepatic abnormality than increased hæmolysis, though both may play a part. It is interesting to note that the urine in cases of acute yellow atrophy usually contains a large amount of bilirubin up to the time of death; this fact gives evidence of a constant formation and excretion of bile pigment by the liver in spite of severe injury to its cells. The milder forms of icterus neonatorum have been attributed to compression of the smaller bile ducts by the distended radicals of the portal vein, but there is no reason why they should not be regarded as hæmohepatogenous in origin; the more severe forms of this disease may depend upon congenital absence of the main ducts, congenital syphilitic hepatitis or septic poisoning associated with phlebitis of the umbilical vein. A form of jaundice has been described in which the coloration immediately follows a nervous shock of some kind. No satisfactory explanation has been given. It has been attributed to spasm of the common bile duct, but the rapid onset renders this improbable.

The passage of the bile pigments from the ducts to the blood is apparently effected by way of the lymph channels. If the bile duct be ligatured, the lymphatics of the liver, distended with bile, can be traced to the thoracic duct. Again, it has been shown that bile pigment appears in the urine in a few hours after experimental closure of the bile duct, whilst the additional ligature of the thoracic duct retards this appearance for a week or fourteen days. This experiment does not succeed in every case: bile may appear in the urine within a day or two in spite of the second ligature. Such cases may result from a rupture of the distended bile capillaries into neighbouring blood-vessels, as has been demonstrated in advanced cases of obstructive jaundice. The anatomical arrangement of parts renders possible a transference of this nature; the blood capillaries come into direct contact with the liver cells and communicate with canaliculi in their substance, whilst similar canaliculi pass from the same cells into the bile channels.

The pigmentation of obstructive jaundice is exhibited by the skin, mucous membranes, and certain fluids of the body—urine, sweat, and occasionally saliva and milk. The coloration of the skin ranges from a light yellow in catarrhal jaundice to a deep green or bronze in complete obstruction of long standing, that of the urine from a light greenish yellow to a deep black green. The pigmentation of the fæces varies with the nature of the condition. Should the obstruction be complete, the stools are of a drab or slate-grey colour, due to the absence of bile pigment and in part to the presence of undigested fat. In cases of hæmohepatogenous jaundice, where the obstruction is not as a rule complete, the fæces retain part of their normal colour.

Many authors regard *all* the hæmolytic pigmentations as being essentially due to biliary obstruction; in other words, they regard the disintegration of hæmoglobin as a function of the liver alone. Others take the opposite extreme, and maintain that there is merely a difference of degree between this action of the liver and that of the body tissues in general. The former base their conclusions on a single series of observations: in birds and amphibians it is possible to short-circuit the portal circulation and so exclude the liver. It has been found that under these conditions arseniuretted hydrogen fails to promote jaundice, although it ordinarily takes such effect. Hæmoglobin alone is discharged from the kidneys, no other adventitious pigment. For the reason that arseniuretted hydrogen is unable to bring about a break-down of the hæmoglobin molecule, they assume that no other agent, natural or otherwise, is capable of

attacking its integrity without the aid of the liver—a conclusion more interesting than convincing. The supporters of the latter theory have made use of recent observations which seem to indicate that the conversion of hæmoglobin into bilirubin is brought about by proteolytic ferments in the presence of a carbohydrate. Such a combination of ferments with carbohydrate and hæmoglobin is most likely to occur in the liver, and therefore it is in the liver that the formation of bile pigment usually takes place. If the liver be cut off from the circulation, as in the experiment cited, any excess of carbohydrate in blood or tissues is immediately utilised. It is this removal of carbohydrate, rather than the removal of some peculiar activity of hepatic cells, which arrests the formation of bilirubin; should the carbohydrate still remain in circulation, it would, in combination with the proteolytic ferments of the tissues, proceed to the formation of bilirubin elsewhere. But further evidence is required to lend probability to such a view.

An intermediate course, though necessarily speculative in character, seems to receive accord from the data in our possession. The final stages of hæmoglobin breakdown are essentially due to hepatic function; but, although the liver is usually responsible for the complete process, the earlier changes may, under certain conditions, find place in other parts of the body.

The causation of abnormal pigmentation by the melanins is to be sought in an augmentation of one or another of the factors responsible for their formation.

Addison's disease presents a well-marked example of this type. It appears to follow an increased circulation of certain aromatic compounds in the body. Addison described the cutaneous coloration as of "a dingy or smoky appearance, of various tints or shades, of deep amber or chestnut brown. In one instance the skin was so universally and deeply darkened that, but for the particular features, the patient might have been mistaken for a mulatto." The mucous membranes, too, are generally pigmented. The disease is due to lesions of the suprarenal glands; of these, tubercular caseation is the most common; others are cirrhotic in character, and may also be tubercular in origin; malignant disease and thrombosis of the suprarenal vein have given rise to a few cases. The suprarenals have betrayed no obvious change on several occasions where death has been said to result from Addison's disease; it has been suggested that the carotid and coccygeal glands subserve the same functions as the suprarenal capsules, and that pathological changes in these glands may have caused death before the suprarenals were affected.

Halle's observations indicate that tyrosin is a precursor of adrenalin; he regards the latter as the product of a change brought about by a ferment in the suprarenal; thus he has found that an aseptic mixture of tyrosin and emulsified suprarenal results in the formation of adrenalin. Disease of the suprarenal would abolish the activity of its peculiar ferment, and with it the conversion of tryrosin and allied bodies into adrenalin. These bodies would consequently accumulate in the tissues, and, as precursors of melanin, would tend towards an increased formation of that pigment wherever they come under the influence of the other essential factors. The latter operate in the skin, and therefore a superficial pigmentation results. Such an explanation accords with the negative results obtained, so far as pigmentation is concerned, on treating patients with adrenalin. It has been observed that darker patches exist here and there amongst the general stain. These are found in the natural folds of the skin, where the opposing surfaces lead to friction; they are also found where the belt, braces, or garters cause some degree of irritation; and they appear to follow any form of dermatitis. At such points it is clear that an additional stimulus to melanin formation is provided by the introduction of an irritative factor, and hence the pigmentation is doubly marked. Similarly the coloration is more intense in exposed parts where the action of light prevails.

It is highly probable that the cutaneous pigmentation of chronic constipation depends upon an excessive melanin formation, and that in turn upon an increased production and circulation of its aromatic precursors. In this disease the skin assumes a general dingy appearance, and exhibits areas of exaggerated pigmentation corresponding to such surfaces as are exposed to friction or other irritative stimulus. Light-haired subjects under similar conditions fail to show these pigmentary changes; this fact incidentally lends support to the melanotic nature of the coloration, whilst it instances the absence of active melanogenetic enzymes in individuals of this type.

It would appear obvious, on *a priori* grounds, that a delay in the passage of food and fæces through the intestines should lead to increased effects of bacterial activity—the time factor alone would determine this result. These effects of bacterial activity have been shown to be a production of aromatic bodies with which the organism is incapable of dealing; they therefore circulate as such after absorption. It is permissible to suppose that these compounds, as precursors of melanin, may give rise to an increased formation of that pigment when themselves augmented. Unfortunately, direct evidence of their augmentation in chronic constipation is not forthcoming. Estimations of ethereal sulphates in the urine have yielded contradictory results, although, on the whole, they have indicated an increased absorption of the aromatic bodies. Whether this is due to a definite extension of bacterial decomposition, or whether it is merely due to absorption over a longer period, is a matter for speculation. There is some reason to believe that constipation may actually diminish bacterial activity in the intestines; the fæces of constipated patients were found by Strasburger to contain fewer bacteria than those of normal individuals. Yet it is tempting to assume in certain cases not merely an intestinal hyperactivity, but an actual passage of bacteria from the gut into the body, a condition of subinfection indicated by many clinical observations. A transference of bacteria

from the gut in marked conditions of intestinal inflammation is undoubted. In cases of chronic irritation of the gut, Adami has claimed to demonstrate the existence of broken-down bacteria in mesenteric glands and liver cells. He considers that a certain number of microbes is continually gaining admission into the system, even of a healthy individual, by way of the intestinal wall. Normally they are rapidly destroyed, but an increased admission naturally corresponds to some degree of growth within the tissues. This may occur in constipation. On this assumption, the bacteria introduced may carry on their work of amino acid destruction and liberation of unassailable aromatic compounds actually within the body. Thus the formation of melanin. At the same time this infection would lead to some degree of hæmolysis, and it would therefore be necessary to regard the pigmentation as hæmatogenous in part; intestinal decomposition alone would lead to an increased formation of urobilin.

Ochronosis is a disease as rare in occurrence as the foregoing is common. Yet the characteristic pigmentation appears to depend upon factors similar in nature; it is apparently of melanotic type, and is determined by a certain profusion of benzenoid compounds in the body. The condition presents a peculiar blackish discoloration of cartilages, ligaments, and occasionally of skin and urine. Of eleven cases in which this pigmentation of cartilage was observed, the skin was visibly affected in three, and the urine in five. In two instances the darkening of urine was due to true alkaptonuria; aromatic compounds of some kind were presumably responsible for all. Carbolic acid poisoning seems to have played a comparatively frequent part in ochronosis; the case recently observed in this hospital was apparently due to such a cause. The occurrence of alkaptonuria in at least two cases out of eleven indicates something more than a coincidence where both conditions are so rare. Alkaptonuria has been shown to result from an inefficient katabolism of certain aromatic amino-acids, with the consequent establishment of compounds which the body is unable to destroy. When excreted, these are readily oxidised, and give rise to a pigment black or brown in colour. Since this process is frequently effected by exposure to air alone, a rapid and constant oxidation would be anticipated where melanogenetic oxidases of the skin take up the part. The invariable appearance of cutaneous pigmentation as an accompaniment of alkaptonuria would receive a simple explanation on the lines already indicated. Why, therefore, should ochronosis be so rare in alkaptonurics? And why should pigmentation affect cartilage and ligament rather than the skin? These questions curb out discursive tendencies, and illustrate the extent of our ignorance. Clearly we have at present but a glimmering of the truth.

Alkaptonuria appears to be a family anomaly; although no instance of transmission from parent to child has been recorded, it has occurred with comparative frequency in brothers and sisters. There is considerable evidence to show that the condition bears some relation to consanguinity of parents; subjects have requently been children of first cousins. Alkaptonuria, is a freak of metabolism rather than a disease; it presents a chemical abnormality analogous to structural malformations of hereditary type. The latter are more widely recognised for the reason that our knowledge of physiological chemistry is in its infancy, whilst anatomical facts are obvious to all. Doubtless, further instances will be forthcoming as our means of observation are extended. For the present, the hereditary features of albinism and cystinuria give evidence that alkaptonuria does not exist alone as a type of chemical "sport."

It has been advanced that certain stimuli—thermal, luminous, chemical, mechanical or nervous—give rise to an increased production of melanin by placing an additional supply of energy at the disposal of the cutaneous catylases; these stimuli may act directly and singly, or, in causing some degree of inflammation, summon others to their aid. Where severe dermatitis is introduced, however, hæmatogenous pigment usually preponderates, and so the pigmentation becomes complex in character, whilst the melanotic factor is obscured.

To increased melanin formation of this nature is the pigmentation of arsenical poisoning due. Instead of supplying additional precursors, the arsenic appears to act as a chemical stimulus which enables the melanin-secreting cells to attack more vigorously their ordinary stock of material. The coloration produced is very like that of Addison's disease in mild degree, except that it is absent from the mouth.

The pigmentary effects of light, heat and mechanical irritation appear only incidentally in disease. The former may give rise to a general deposit of melanin or to localised areas of pigmentation, ephelides or freckles. In addition to the results of mechanical irritation already described, there is a further condition known as "vagabond's skin," which appears to follow the constant itching and scratching produced by pediculi.

The influence of nervous stimulation is undoubtedly responsible for many abnormalities of pigmentation, yet too much importance has been attributed to this factor, whilst others have been generally neglected. All the melanotic pigmentations have, at one time or another, been supposed to originate directly from a nervous process. In anæsthetic leprosy there is ample demonstration of the part which nervous influence can play. In the preliminary stages of this disease, before anæsthesia has occurred, the areas corresponding to nerves undergoing inflammatory change become pigmented; when the nerves are destroyed, white areas appear in the centre of these pigmented patches corresponding to the anæsthetic region. In certain forms of multiple neuromata, patches of brownish pigmentation of the skin are constantly present. Leukopathia acquisita, or vitiligo, has been attributed to nerve changes. This disease, more common in black than white races, is characterised by the production of whitish pigment-free blotches, often symmetrical, usually on the face, neck and hands. It may

occur spontaneously or occasionally after the infectious fevers. The phenomenon is essentially due to a disappearance of melanin from the affected areas; both skin and hair become bleached. The use of adrenalin in treatment is as irrational as it has been unsuccessful. There are cases on record in which the hair has whitened as a result of nervous shock, and in which the change has been too rapid to admit of other explanation.

Some cases of white hair are due to a deficiency or absence of melanin production rather than to a removal of pigment. In these types the presence of a chromogen or melanogen has been demonstrated, and so we may assume an inefficient activity or absence of the melanase. To this lack of melanogenetic enzymes is leukopathia congenita, or albinism, due. Albinism may affect the pigmentation of the body in general: a characteristic subject has clear, white or rosy transparent skin, white, or yellowish white, silky hair, and pink eyes. In partial albinism the skin or hair presents whitish patches in various parts. The condition cannot be considered pathological; there is only a slight difference of degree between the albino and the ordinary individual with red or yellow hair. There is a tendency to associate acute rheumatism with red-haired subjects; perhaps it is too much to suggest a connection between the presence of a reducing body such as formic acid in the former, and the incomplete activity of oxidative enzymes in the latter.

In women who are pregnant, menstruating, or subject to disease of the genital organs, a melanotic coloration known as chloasma uterinum is frequently observed. It is difficult to assign a cause to this pigmentation. Possibly it may result from a uterine infection analogous to that condition which has been supposed to originate from the intestines, or it may represent a function of the internal secretion of the ovary.

Exophthalmic goitre, phthisis, and malignant disease are frequently accompanied by varying grades of cutaneous pigmentation. Superficial appearances suggest melanin, but the nature and causes of these phenomena are alike unknown. The common occurrence of anæmia and occasionally of urobilinuria and hæmatoporphyrinuria in these and other diseases which show a mild coloration of the skin may indicate a hæmatogenous factor in the origin of the underlying pigment.

Finally, melanin is exhibited in enormous quantities in certain varieties of neoplasm, both locally and in the blood and urine. These melanomata may represent an overgrowth of cells which play a part in melanin metabolism—an increase of productive cells with corresponding extension of functional activity, or increase of destructive cells with loss of their peculiar abilities. The former view apparently assigns to epithelial cells a part in the formation of a growth essentially sarcomatous, whilst it involves the vast and sudden extension of a function highly specialised. For these reasons, the latter process is more probable; moreover, it explains the nature of the so-called "chromatophores" in the corium. On the other hand, the connection between excessive function and excessive growth may be secondary. Until some explanation of uncomplicated neoplasia is found, we cannot hope to understand a case where abnormality of function is included.

Reviews, etc.

Books for review should be addressed to The Editor, Gazette Office, Guy's Hospital, S.E. Their price should in every case be stated.

Manual of Operative Surgery. Vol. 2. By John Fairbairn Binnie, A.M., C.M. (Aberd.). (H. K. Lewis.) Price, 14s. net.

The aim of this manual is particularly to give aid to the junior surgeon when he is brought face to face with the difficult or unusual in his practice.

In the explanation of operations the author relies to a very large extent upon illustrations, which are numerous and excellent; in consequence, the verbal description is very brief, and we have experienced no weariness in reading the book. In two places only is there any difficulty in understanding the text—viz., in the subject which the author refers to as cineplastic surgery, and in the operations for hallux valgus; in the former, one or two more diagrams would be helpful, and in the latter confusion would be avoided if the author referred to the tibial aspect of the foot as the inner aspect.

This volume comprises the surgery of the limbs, and describes a large number of classical operations and others less frequently demanded, some of which are still *sub judice*.

The book opens with a very clear account of that fascinating subject—vascular surgery; and in this branch of surgery America leads the way. The author realises this, and makes the following apology: "Some of the operations almost appear as if they were the offspring of a superheated imagination."

The chapters on fractures are excellent, and some of Mr. Arbuthnot Lane's plates illustrating operations are shown.

In the treatment of compound fracture, that fundamental point is emphasized, viz., the object of the operation is the treatment of the deep wound, and the treatment of the fracture is a secondary consideration.

There are so many other good things that it is difficult to pick out any particular one; but the sections on acquired and congenital club-foot are very good.

The book is so excellent in its descriptions, and the illustrations, the principles, and indications so sound, that we should welcome the conversion of this manual into a text-book.

Change of Address.

W. J. Burroughs, M.R.C.S., L.R.C.P. Lond., from 75, Camden Road, N.W., to 25, Welbeck Street, Cavendish Square, W.

H. Hunter Carter, M.B., B.S. Lond., M.R.C.S., L.R.C.P., from 4, Thirsk Terrace, Northallerton, to 5, Arncliffe Terrace, Northallerton.

J. W. Doherty, L.D.S., from Steadham House, Surbiton Hill, to 140, Harley Street, W. Telephone, 1720 Paddington.

D. C. Druitt, M.R.C.S. Eng., L.R.C.P., from Guy's Hospital, to c/o Dr. Bartlett, Saffron Walden, Essex.

C. C. Holman, M.B., B.C. Camb., M.R.C.S., L.R C.P., from Gate House, East Hoathley, Sussex, to Norfolk and Norwich Hospital, Norwich.

E. P. Minett, M.D. Brux., D.P.H., D.T.M. & H. Cantab., M.R.C.S., L.R.C.P., F.C.S., from Royal London Ophthalmic Hospital and Cancer Institute, to be Assistant Government Bacteriologist, Georgetown, British Guiana, W Indies. (Colonial Office appointment.)

J. Lewin Payne, from 44, Devonshire Street, W., to 18, Portland Place, W.

W. E. Robinson, M.D., B.Ch. Oxon., M.R.C.S., L.R.C.P., from Sedgehill, Redlands Road, Reading, to 206, King's Road, Chelsea, S.W.

Sport.

Rugby Football.

Kent County Rugby Cup.—Final Round.

GUY'S v. CATFORD BRIDGE.

This match was played at Blackheath on Saturday, April 2nd, but so many men were still away on their Easter holidays that the team who eventually did duty was neither a 1st, 2nd or 3rd XV., but a mixture of all three, with the 2nd predominating. The 2nd XV. had won their way so far, and it was a great pity that the full strength of the Hospital second string could not have taken the field in this the Final Round. Catford Bridge won, and quite deserved it on the afternoon's play. They were well served forward, a department in which for once the Hospital were not very conspicuous. The Hospital attacked at first, but after about ten minutes had elapsed Lindow for Catford doubled inside, when he looked like passing, and got a clever try, which Kerr converted; and before very long Lindow added four more points by dropping a nice goal when he found the way for a run barred. This was all the scoring during the first half, and frankly, it must be admitted, Guy's had not been very dangerous, except on one occasion, when a strong forward rush compelled Catford to concede a minor.

After half-time Guy's played much better, but it was Catford who scored next. The ball was kicked over Guy's line, and Tribe followed up just in time to gain an unconverted try. Stranack among the forwards, well assisted by Danby, also Jones, Medlock and Stringer, had done all they could to stem the attacks of Catford, and after several brilliant attempts to get through on the part of Stringer, well led up to by Jones and Medlock, the wing man ran clean round and scored. Glendining took a hurried kick, and missed an opportunity of goaling. Just before the end Stringer put on another try, which Medlock easily goaled; but previous to this, owing to some weak tackling, Helder was let through, and the try he gained was converted by Francis Helder from an easy position, the final score reading: Catford Bridge, 3 goals (1 dropped), 1 try (17 points); Guy's, 1 goal, 1 try (8 points). Team:—

Guy's.—G. E. W. Lacey (back); L. B. Stringer, J. P. Jones, W. S. Roe, H. Hoby (three-quarters); C. H. Medlock, J. P. Monaghan (halves); W. S. Stranack, V. Glendining, H. R. Danby, T. Parry Jones, M. Tweed, W. G. Smythe, H. Gibb, L. C. D. Irvine.

Referee: Mr. B. C. Hartley.

The Cup was afterwards presented to the Catford Bridge Captain by Mr. Rowland Hill, President of the Kent Rugby Football Union, who spoke very kindly of Guy's as being both excellent sportsmen, and loyal supporters of Kent; and mentioned that Guy's had done much for Kent Rugby, and for the grand old game generally. Mr. Stringer spoke for the Hospital, and referred to the sporting qualities of Catford. Mr. Geo. Harnett finished the oratory in eloquent fashion, and stated that no County Secretary had ever received more loyal support than he had from the Rugby players of Guy's Hospital.

Appointments.

University of Leeds.

The following have been appointed External Examiners in the Faculty of Medicine:—

In Medicine and Mental Diseases—Dr. Lauriston E. Shaw.

In Surgery—Mr. L. A. Dunn.

University of London.

Appointed Examiners for Internal Students for 1910.

Physiology—Dr. M. S. Pembrey and Dr. E. S. Starling.

Zoology—R. Assheton, M.A.

Appointed Esquire Bedell.

H. E. Vincent, M.D., B.S.

Periodicals Received.—The Hospital; The Clinical Journal; London Hospital Gazette; St. Bartholomew's Hospital Journal; The Nursing Times; St. Thomas's Hospital Gazette; Polyclinic; The Prescriber; South African Medical Record.

Birth.

LACEY.—On April 4th, at 196, Burrage Road, Plumstead, the wife of B. Warner Lacey, M.B., of a son.

Marriages.

CARTER—LEE.—On March 31st, at Todwick, H. H. Carter, M.B. Lond., of Northallerton, to Ada Mary, only daughter of the late J. F. Lee, of Todwick, near Sheffield.

STEVENSON—VERRAN.—On April 14th, at the Streatham Wesleyan Church, by the Rev. T. H. Barratt, B.A., assisted by the Rev. Frederick Green, Claude Maberley Stevenson, M.B., B.C. Cantab., son of the late Sir Thomas Stevenson, M.D., to Dorothy Thirza, second daughter of Joseph Verran, of Streatham Hill, S.W.

Death.

CARPENTER.—On March 27th, George Carpenter, M.D. Lond., M.R.C.P. Lond., M.R.C.S., L.S.A., of Welbeck Street, W., in his 51st year.

Ed.—A. N. C.

GUY'S HOSPITAL GAZETTE.

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Calendar of Coming Events and Ensuing Take-in Weeks.

April.
Sat. 30.
May.
Mon. 2. Summer Session begins.
Final M.B., B.S. Lond., Examination begins.
Thur. 5. Messrs. Dunn and Rowlands' Take-in (Messrs. Lucey and Francis).
Primary Fellowship Examination begins.
Mon. 9. Clinical Lecture by Sir Cooper Perry (Dermatology), 1.15 p.m.
Wed. 11. Choral and Orchestral Concert, Physiological Theatre, 8 p.m.
Thur. 12. Sir Alfred Fripp and Mr. Turner's Take-in (Messrs. Brown and Elliott).

Passim.

THE second concert of the Hospital Choral and Orchestral Society's season is to be given in the Physiological Theatre on May 11th next; an excellent and varied programme has been rehearsed, and the spirit and life that Mr. Carey is able to instil into his choirs we heard last December. The orchestral section have also been at work all the winter under Mr. Eason's direction, and are sure to be well worth hearing. Tickets may be obtained, price 2s. 6d., from the Secretary, L. C. Dundas Irvine, and he has also a limited number of 1s. seats for the back of the theatre. After the care and energy that has been given to produce this concert, we hope that it will be well attended, for the audience at the last concert in December, though they lacked nothing in enthusiasm, left something to be desired in numbers, the hall being only a little more than half full. We can fully assure those who think of going that they will spend a thoroughly enjoyable evening.

GUY'S HOSPITAL RUGBY CLUB BALL.—It was suggested during the Rugby season that a dance should be held if the Hospital XV. still retained the Cup this year, and so broke the sequence of London and Guy's alternate victories, as in the past few years. The keenness shown, and the success achieved by the second, third, and fourth fifteens, stimulated the idea still further, and a meeting on Friday, April 22nd, carried the proposal unanimously. If the dance is to be the success the occasion demands it must be supported by the hospital in general. We make a special appeal to old Guy's men who follow the sports of the Hospital with so much interest, as it is hoped to make the function one at which both Past and Present may meet. The committee have decided that the dance be held at "The Galleries," Prince's Restaurant, Piccadilly, on Monday, June 20th. The price of tickets is

12/6 each, and they may be had on application to F. D. Saner and J. G. Saner, Hon. Secs., The College, Guy's Hospital, S.E.

The Pageant of London, to be held next month at the Crystal Palace, has "caught on" at the hospital. A letter was published in our last issue asking for men willing to take part in these revels, and we hear that a large number have joined, and, some on horseback and some on foot, are prepared to appear on Tuesday and Friday afternoons throughout the pageant. The scene chosen for the medical students to represent is called, appropriately enough, "The Social Upheaval." We hope to have the pleasure of seeing Dr. Rippmann starring as Wat Tyler, or some other important part. Rehearsals for the pageant commence in the second week in May, so there is still time for any of our readers who wish to socially upheave to send in their names as performers. We may add that performers in the pageant will each receive a free season ticket, and will be privileged to obtain specially reduced terms for railway tickets and refreshments.

The following appointments have been made by the House Committee upon the recommendation of the Medical Committee:—to be Obstetric Resident, Mr. A. H. Crook; to be Out-patient Officer (to fill the vacancy caused by Mr. Duvivier's retirement through illness), Mr. H. L. Attwater.

In accordance with the policy of the Governors as regards special departments, an out-patient day for nervous diseases has lately been started. These cases are seen on Wednesday mornings, at 10, on the third floor of the Out-patient Department, and Dr. Hertz gives his Neurological Demonstrations at 12.15 on the same days.

The following Prizes and Scholarships have been awarded as the result of examinations held last term:—Junior Proficiency Prizes, 1909—1910: Mr. J. F. G. Richards, £20; O. R. L. Wilson, £15; G. S. Miller and W. Robinson (equal), £5 each. Michael Harris Prize for Anatomy: Mr. J. F. G. Richards, £10. The Sands-Cox Scholarship in Physiology: Messrs. G. S. Miller, W. Robinson, W. L. Webb (equal), Scholarship divided. Golding-Bird Gold Medal and Scholarship in Bacteriology: Mr. A. Neville Cox, Medal and Scholarship; Mr. A. H. G. Burton, Certificate.

A somewhat strange condition attaches to a legacy lately made to the hospital in the will of Miss Martha Elizabeth Gray, of Hatcham Lodge, New Cross Road, who died on March 17th, at the age of 94. "The testatrix left £1,000 to Guy's Hospital for the endowment of a bed for males (*sic*) in the Queen Victoria Ward of the hospital."

We are asked to remind our readers in distant parts of the world that it is now time they should return, if they have not done so already, the pink slips which they will find in their Clubs' Union Blue Books. On these pink slips they should record any appointments or distinctions they have gained during the year, and any changes of address, also their births, marriages, or deaths, so that the necessary alterations may be made in the next issue of the Blue Book. During the few years this plan has been in existence it has been a great success, and if only old members will co-operate by supplying information of the kind we have indicated the annual publication of the Clubs' Union, instead of being an uninteresting summary of rules and regulations, will become an entertaining and informative volume.

There is at least one person who is looking out "anxiously" for this present number of the Gazette, and that is the editor of the *St. Mary's Hospital Gazette*. He says so himself at the end of one of his scintillating paragraphs, which in the last number of his journal appear to run through the whole gamut of the sublime and the ridiculous. Why he is looking out anxiously we are not quite clear. We have an idea that he hopes to convert us to his own breathless Carmelite style of journalism. "Modern journalism and news have nothing in common. Facts cramp the style," he tells us. In other words, if you see it in *St. Mary's Hospital Gazette*,

it isn't so. At least, he has taken care that nothing shall cramp *his* style. His "Notes" bristle with epigram and paradox, and we have seldom enjoyed anything in our hospital exchanges so much as his clever efforts. He offers us advice: let us retaliate. We beg him not to be too clever, for the sake of dull readers like ourselves, and for his own, for we dread to hear of his becoming involved in libel actions, like his admired models *John Bull* and the *Daily Mail*. Already, it seems, a storm of criticism has raged and howled around his head. But possibly he seeks a libel action for the sake of the advertisement!

In his next paragraph, having expressed his sympathy with us for our lack of his own knowledge of the science of fooling, he sounds a note of warning. "The thought of a serious soul forsaking the sea of solemnity for the shallows of frivolity is unnerving. This were tragedy indeed, and we should hold ourselves responsible." For it seems we are too dull, or old, to learn the science of fooling: "It is the expression of temperament. It cannot be taught"—even by our spirited contemporary—"It is the art of life." So there is no hope for us! And the cream of the jest is that this artist of life will fancy, if he ever sees these lines, that he has caught us taking him seriously, as he supposes we take everything else. We look forward, "anxiously," to his next batch of notes.

At a public meeting held in Brighton towards the close of last year, to inaugurate the Brighton and Sussex Branch of the Research Defence Society, a very excellent speech was made by an old Guy's man, Dr. R. J. Ryle, who summarised very clearly the case against anti-vivisection by explaining some of the advances in practical medicine which have been gained by this method of physiological research. This speech has lately been issued as a pamphlet (The Truth about Vivisection. No. VI. *What the Doctor says.*) by the Research Defence Society, and in this form it should be valuable in explaining the real position to that very large class of non-scientific persons, who are inclined to favour anti-vivisection, simply because of sentiment on the one hand, and lack of knowledge of the meaning and method of research on the other. In particular, the non-scientific person finds it difficult to appreciate the value of researches which have no immediate practical application; the value of testing a new drug on an animal he can understand, but experiments such as the cutting out of a pancreas, for instance, seem to him mere useless brutality. This point is very clearly dealt with by Dr. Ryle, who says of these people:—"They have never stopped to inquire concerning the actual work of a physiologist, and they are apt to suppose that the experimenters are a set of inquisitive and rather mischievous people (generally it is believed that they are medical students) who, after catching a cat or rabbit, proceed to snip off a bit here or a bit there from the unfortunate animal, or to poke a red hot skewer into it, just to see what happens;" and afterwards he explains how the work of Harvey—based largely on vivisection—has been to physiology, and, later, to practical medicine, as that of Newton was to astronomy, and, later, to practical navigation.

Change of Address.

Fleet Surgeon W. Bett, R.N., from H.M.S. *Sutlej*, to the Cadets' Hospital, Royal Naval College, Dartmouth.

F. N. Doubleday, L.D.S., R.C.S. Eng., from Guy's Hospital, to 4, St. Thomas's Street, S.E. (Telephone, 3583 Central.)

C. F. L. Leipoldt, F.R.C.S. Eng., from 416, New Cross Road, S.E., to 10, Buckingham Street, Strand, W.C. (Telephone, 223 City.)

A. H. Pickett, D.M.D. Harv., L.D.S. Eng., from 145, Upper Grosvenor Road, Tunbridge Wells, to 24, Cornfield Road, Eastbourne.

J. Roberts, L.D.S., from 8, Church Road, Tunbridge Wells, to Royal Naval Barracks, Chatham.

(The Editor will be very glad to receive a postcard with notes of any change of address.)

Periodicals Received.—The Hospital; The Clinical Journal; The Nursing Times; Manchester University Magazine; Le Mois Médical; St. Mary's Hospital Gazette; South African Medical Record; Archives of the Roentgen Ray.

A Weird Adventure.

"It must be ten years ago," said the Doctor, "since the incident that I am going to relate occurred. I was then a country practitioner at C——, in Warwickshire, a village of about eight hundred inhabitants. I was a bachelor, and lived with one servant in a small red brick house, about two hundred yards away from the last cottage in the village. It was the best house in the place next to the Vicarage, at the other end. My surgery was detached from the dwelling-house, being an addition of galvanized iron to the coach-house at the back. It was a snug little place, and usually warmed by a small oil stove. The window was placed somewhat high from the ground, and outside there was a strong network of wire to keep out birds—and cats—when the window was open.

"One winter evening late, I was in the surgery turning out the contents of a small wooden box that had belonged to a brother of mine who had died of fever in India. It contained all sorts of nicknacks, queer things in brass from Cawnpore, old letters, old bills, an Eastern bridle, a writing case and miscellaneous rubbish. While rummaging among the papers I came across a small packet done up with a peculiar kind of thin brown cord knotted in many places. On the packet was written, in faded ink, in my brother's hand:

'The Fakir's Present.'

"This aroused my curiosity, for I had heard my brother was given to the study of native lore and to the investigation of practices usually hidden from Europeans. I cut the string, and unwound the mouldy-looking paper, and came upon a small glass bottle, corked, and sealed with wax. It contained some brown liquid that looked rather like laudanum. I determined to open it. I took up the surgery spatula intending to break the wax covering the cork. As I gave the sealed top a sharp tap, the bottle broke into a thousand fragments, and its entire contents were spilt over my clothes. I shall never in my life forget the horrible stench that arose and filled the little room at that moment. Its powerful musk-like odour pervaded the place like some poisonous gas, and nearly stupefied me. Instinctively I rushed to the window, dashed it open, and holding my face close to the wire net-work, gulped in the cold fresh air outside. Every time I drew back into the room I felt a throbbing sensation in my head and a peculiar dizziness. This warned me that retreat by the door was impossible, for the present at all events. I shook the wire-netting, hoping to displace it, but it was immovable. I could do nothing but remain where I was at my breathing space, waiting for the noxious vapour to be dispersed. Suddenly, as I stood there with my face pressed against the wire-netting, I heard the most awful caterwauling imaginable!

"Not one cat, but many, filled the air with hideous cries. As I looked into the yard I could see their shadowy forms with opalescent eyes moving about, and from their appearance it was evident that their whole attention was concentrated upon my prison. I guessed at once that their keen scent had been attracted by the vapours that held me prisoner. Meanwhile the hideous cries increased in volume as the feline company became augmented in numbers. What struck me particularly was that none of the brutes attacked one another. Each seemed only intent on what brought them all to the spot.

"I certainly counted thirty different cats in the yard. Tabby, black, white, hideous yellow, and spotted mongrels were all represented in that shifting crowd. As I looked from my window into the semi-darkness, the balls of opalescent fire that hung half a foot from the ground in a semicircle seemed to glow brighter. The hideous chorus became louder, and the dark forms, bearing, as it were, devil's lanterns, slowly advanced.

"As the brutes drew nearer I could see that their hair stood on end, their tails bristling like bottle brushes. A moment later two huge tabbies leapt at the wire netting, a few inches from my face. Involuntarily I sprang back, only to be nearly suffocated by the sickly vapours inside. I clung once more to my breathing space, and received a severe scratching for my pains. By a lucky chance my hand touched the steel spatula that lay on the narrow table below the window. I grasped it firmly and prepared for battle with the now frenzied beasts outside. The din of the squalling cats was truly horrible, and the situation was one of peculiar danger. If I retreated into the room I ran the risk of being suffocated by the vapours that arose from the liquid I had spilt over my clothes. If I stuck to my breathing space, the window, I ran the risk of being seriously injured by the attack of these maddened cats. I chose the latter as the lesser risk. My God, what a position to be in! There I stood with my face close against the wire net-work, gulping in the outside air for very life, and the while, with cramped arm, stabbing wildly at the furry forms that every moment would leap up from the semi-darkness in front. The blunt-pointed spatula was a poor weapon, and in the awkward position which I was compelled to maintain, did little damage to the infuriated beasts. As I struck into the soft mass that rose before my eyes, I could hear the half-choked cry of rage and pain as the creature fell back among its fellows. Repulse seemed only to add fury to the efforts of the besiegers, for the cries increased in intensity and their fire-like eyes glowed with greater brightness as they darted hither and thither.

"I could hear now a new sound above me, for some of the cats had leapt upon the roof of the little surgery, and their claws grated loudly on the fluted iron. I cried for help on the vague chance of being heard by some late traveller on the high road. No answering shout cheered me as I fought madly on, stabbing with my ineffectual weapon at my ever-active foes. More than once my blow would miss its aim, and a claw would strike my face and inflict a painful wound, the scars of which I still possess, though, happily, now concealed by my beard.

"There was one cat in particular which seemed more aggressive than its fellows. He was a huge ugly yellow one with a torn ear. I had one terrible tussle with him. I

had missed my stab at him, and in a moment the creature was clawing at me through the wire. I seized his paws and held on with all my strength, though his claws dug into my fingers like hooked thorns. My face almost touched his horrible head as he spat at me through the network. By a quick movement I released one paw, and thrust my spatula down his throat. That settled him; he dropped down, a lifeless mass, among his companions. For a moment the attack wavered as the cats smelt at the yellow corpse lying in a red pool on the cobble stones of the yard. Then hell itself seemed to be let loose, as the brutes hurled themselves with renewed fury upon the little outhouse. I struck wildly at the bobbing forms as they appeared, receiving a terrible scratching in return. I reached down with my left hand a bottle of nitric acid from a shelf, and with it blinded more than one of my assailants. Still the attack continued, for reinforcements seemed to appear as time went on. The din was horrible, the wailing shrieks mingling with growl and hiss, while before me danced the flash of glowing eyes.

"How long I fought thus with my strange and horrible foes I have never known. I have a dim recollection of a feeling of faintness overtaking me as I stood at the window facing the attacking foes. I seemed to hear a familiar voice shouting above the din, while a spurt of cold water struck the wirework, and, breaking, drenched me to the skin. I fell backwards with the shock, and as I did so the stifling vapours that clung around me overpowered me, and I remembered no more.

* * * *

"When I came to my senses, I was in my own bed with the familiar faces of my faithful house-keeper and the groom about me. The latter, happening to be passing late, had heard the commotion, and had come to my rescue with the garden hose, which scattered my enemies most effectually. I was unconscious when the man dragged me out of the surgery after breaking in the door, though almost stifled himself from the strange odour. Once there, this good fellow discovered that my clothes exhaled this noxious vapour, and with the aid of a clasp-knife he quickly set me free of my poisoned garments. I was carried indoors almost naked, and laid upon my bed. Little remains to be told. I never discovered the nature of the terrible poison that had such a horrible fascination for the cats, for my man burnt every vestige of the clothes I wore before I was well enough to be about again. It remains for me an unsolved mystery. And now," added the doctor, as he stretched out his hand towards the whisky, "now you know why I do not like cats."

FREDERICK VICARS.

THE EDITOR will, at all times, be glad to consider articles or sketches, provided that they are accompanied by the writer's name and address, not necessarily for publication. Payment is a matter of arrangement, and the fees that the GAZETTE *can offer are merely nominal, but if the writer desires any remuneration that fact should be stated. Authors who desire reprints of their papers should make their own arrangements with the printers when they return their proofs.*

Dental News.

As announced in the issue of March 19th, the last meeting of the Dental Society's present session was held on March 18th. The subject under discussion :—"That this House considers that the present method of training the Dental Student is antiquated," brought forth a greater number of members (between 40 and 50) than is usual at the final meeting.

The minutes of the previous meeting having been read and confirmed, the following casual communications were brought forward.

Mr. F. BOCQUET BULL.

1.—Models of an upper and a lower jaw of a Kaffir (Bantir tribe) sent by Mr. Hochapfel to Mr. Wynne Rouw. On both right and left sides of these jaws there are three premolars. On one side of the maxilla two are normally situated, the third one being situated between the first and second permanent molars. On the other side two premolars are normally situated, and the third is erupting, and appears as if it would take up its position as on the opposite side. In the mandible the three premolars on either side are arranged triangular fashion, one being inside the arch. Two premolars on either side in the mandible show extensive caries.

2.—Model showing a case of well-marked erosion and attrition.

Mr. R. W. POWELL.

1.—Model showing the transposition of central and lateral incisors.

2.—Three teeth showing the method of "filing" adopted by the natives of North Western Rhodesia.

Mr. SHEPHERD, upon the President's invitation, then proposed the motion of the afternoon. Starting with the Preliminary Examination in General Subjects, which he stated should be the Matriculation Examination of the University of London—(groans)—he proceeded to deal with the Preliminary Science Examination. The great objection to this as at present standing is that a student is allowed to take each part (Chemistry and Physics) separately. To his mind it should be compulsory to pass in both concurrently. A new subject should also be added, viz., Biology. (Groans.) He failed to see how a man could possibly understand the subjects of the general part of the Final Examination without a small knowledge of this important subject. To the lack of this examination in the syllabus he shifted the responsibility of his present extreme difficulty with the Final Examination. (Loud laughter.) He then attacked the First Professional Examination, which he would curtail by eliminating altogether the Metallurgical portion. (Cheers.) The general part of the Final Examination Mr. Shepherd considered to be very fair, and he had only one amendment to make, and that with regard to the Anatomy; it

being, that in place of the dissection of the leg, the dissection of the abdomen and thorax, and perinæum should be undertaken. Referring to the second part of the Final Examination, he would completely do away with the Comparative Anatomy. (Very loud and prolonged cheering.) From the point of view of it making one a proficient practitioner, as well as from the view that a knowledge of it was intellectually necessary, he wished to dissociate himself. In its place he would desire to see a course of Materia Medica, both theoretical and practical. He drove home his point by relating the story of a certain student who, but for the intervention of a House-Surgeon, would have attempted to have comforted his patients with half-a-tumbler full of "neat" Sal Volatile. He concluded his arguments for the motion by advocating that the compulsory practical part of the work should be greatly increased.

Mr. Bull, in opposing the motion, took one by one Mr. Shepherd's ideas of improvement, and attempted, with what success the reader is allowed to judge, to refute them. He failed to see why Mr. Shepherd should choose the London Matriculation as the Preliminary Examination, it being the most difficult of all the entrance examinations to the Universities. Again, why should a man, having to be proved to be proficient in both Chemistry and Physics, be compelled to pass in both at the same time. Taking each one separately, he would probably instil into his mind a deeper knowledge of each subject than by reading up for both at the same examination. Biology, declared Mr. Bull, had been proved to be unnecessary, as witness the great percentage of men who, starting to qualify for the diploma, had succeeded, compared to the percentage of those who had failed. With reference to the omission of Metallurgy, the speaker thought that all would agree that it was most desirable to have a practical knowledge of those metals with which one daily worked, and most essential to have a scientific knowledge of metallurgical methods which are of frequent use in the Dental Laboratory, and of which a good portion of the Metallurgical Syllabus is composed. Mr. Shepherd had found little room for improvement with regard to the general part of the examination, with the exception of the substitution of one part for another in the dissecting room. Why? Was Mr. Shepherd's knowledge of the part he wished to put aside in favour of others so profound, or was it that he wished to gain a closer acquaintance with these new parts? Referring to the omission of Dental Comparative Anatomy, the speaker apparently himself found this subject difficult to justify, as he was only able to advance in its favour its great virtues as a pleasant conversational subject between patient and practitioner. He concluded his opposition of the motion by indignantly refuting the idea that a Guy's man could make such an extraordinary mistake as was shown in the sal volatile incident, and declaring that the practical work performed at the hospital depended not upon the syllabus but upon the man himself.

There were no seconders for or against the motion, but rumour hath it that Mr. Bull was as earnest in his desires to second the motion as Mr. Shepherd was to second the opposition, an event which was happily frustrated by the enforced early retirement of Mr. Shepherd from the meeting.

The President and Messrs. Lacey, Neft, Ruck and Wade also spoke, and from the last-named gentleman was gleaned, whilst he was discoursing on the prehistoric days of odontology, the interesting, but astounding, information that the hammer of Thor was, in reality, a pair of dental forceps.

The House divided, and on a show of hands the motion was declared lost.

Correspondence.

To the Editor of Guy's Hospital Gazette.

The Biennial Dinner, 1910.

Dear Mr. Editor,—In your last issue you were good enough to notify the fact that the forthcoming Biennial Dinner will take place on Friday, July 1st, at the Connaught Rooms, Great Queen Street, W.C.

Dr. Hale White will preside, and the following old Guy's men have accepted the invitation of the Selection Committee to act as Vice-Chairmen, the names being arranged in order of seniority of qualification, from 1858 to 1908:—J. Rand, E. R. Ray, C. Sangster, W. H. Jalland, C. W. Pinching, H. E. Davey, L. Stokes, R. M. H. Randell, A. S. Taylor, C. F. Routh, J. Pendlebury, H. L. E. Wilks, G. Sichel, H. Cooper, H. A. Munro, W. Tyson, W. E. Hills, E. F. Clowes, L. H. McGavin, A. A. Miller, P. W. L. Camps, F. G. Cross, H. A. Cutler, A. R. Brailey, G. A. Ticehurst, O. V. Payne, E. Morgan, W. W. Cook, and H. R. Mullins.

It has been decided to adopt the same plan as in 1908, each Vice-Chairman to preside over a separate table at which old Guy's men qualified about the same period will be seated. The list given above is an ample guarantee that the Committee may look forward to receiving as valuable help from the Vice-Chairmen, as on the last occasion, in promoting a large attendance at the dinner.

The Committee also propose to try and make arrangements whereby old Guy's men living in the country can, if they so desire, be put for the night by others of us who live in or near London.

The charge for a dinner ticket will be 10/6, exclusive of wine. The general satisfaction which was expressed on the last occasion at the absence of speeches, with the consequent increased facility for interchange of greetings between men who have not seen one another for a long time—for years, it may be—decided the Committee to repeat the experiment in 1910.

Before the next Gazette is issued, the letter inviting all Guy's men to make application for seats to be reserved will have been posted. If anyone fails to receive an invitation, or hears of any old Guy's man who has not received one, I should be very much obliged if he would

kindly inform me, in order that the omission may be rectified. It commonly happens that in sending out so many letters—more than 2,000 in all—a name is here and there left out by mistake, or the notice, for some reason, does not reach the person intended.

It is particularly desired to get into touch with old Guy's men who, though usually resident abroad, may be in England in July next.

In accordance with the usual custom, the notices will not be circulated to present students, but copies may be obtained by them from the Librarian. I need not say that applications from present students will be warmly welcomed by those responsible for the arrangements, and I hope we may have a goodly gathering of them to support their contemporary Vice-Chairmen.

The only request that the Hon. Secretary has to make is to ask you, Mr. Editor, and your many readers, to do all you can to help to make the dinner this year as successful as in 1908, by writing to or asking old friends to bear the date of Friday, July 1st, in mind, for it is upon help of this kind that the success of the dinner, and the consequent enjoyment of the evening, depends.

Who is there amongst us who, having been to a "Biennial" on one occasion, does not leave with the firm determination that it is one of those functions which, in future, "never must be missed," unless for some very cogent reason.—I am, Sir, yours sincerely,

JOHN FAWCETT, Hon. Secretary.

66, Wimpole Street, W.
April 28th, 1910.

Medical Officers for Territorial Regiments.

Dear Sir,—Medical Officers are required for certain regiments, artillery units, and field ambulances in the East Anglian Division, some of which have their headquarters at Leyton and elsewhere, within half an hour of Guy's. A few are badly wanted in Norfolk. There are also vacancies for non-commissioned officers and men in the water squads.

Will your readers consider the feasibility of filling these vacancies and taking their share in the work of our citizen army? I will gladly give all information available to anyone calling here between 9 and 6 any day, or to correspondents.—Yours faithfully,

F. E. FREMANTLE, Major R.A.M.C. (T.)
Sanitary Officer, East Anglian Division,
Zetland House, Territorial Force.
22nd April, 1910.

Fund for Mr. A. A. Clark.

Dear Sir,—Will you allow me through the Gazette to thank all those who contributed towards the Fund on my behalf? At the present time I am only engaged for two afternoons weekly, and any further assistance in the way of employment would be greatly appreciated, however small.—I am, dear Sir, yours gratefully,

ARCHIBALD A. CLARK.

24, Pullen's Mansions,
Peacock Street, Newington, S.E.

Solid Carbon Dioxide.

Solid carbon dioxide is one of the latest remedies introduced into materia medica. It is used for the removal of warts and nævi. As is well known, carbon dioxide is a gas under ordinary conditions, but by the application of a pressure equivalent to 35 atmospheres it may be liquefied at 0° C. Liquefied carbon dioxide is a mobile liquid readily soluble in ether and alcohol; when it is allowed to evaporate the temperature becomes so lowered that a portion solidifies. Thus obtained it is in the form of a light powder resembling snow, the temperature of which, on exposure to the air, is about −60°C.

Liquefied carbon dioxide is an article of commerce, and is sold in iron cylinders containing from 7 to 28 lbs. It is obtainable in any town where a soda-water factory is to be found. In the hospital it has been used for many years in the manufacture of aerated waters, and for this purpose 28lb. cylinders, costing 3s. 9d. each, are employed.

To obtain a supply of the solid carbon dioxide from one of these cylinders the following simple method is employed:—A piece of lint, eight inches square, is wrapped round a ruler or other cylinder, and on the outside of this is wrapped a piece of brown paper of the same size. The ruler is then withdrawn, and one end of the hollow receptacle thus made is folded back to close it while the other end is placed over the opening of the carbon dioxide cylinder placed on its side on a bench. The gas is then turned full on, and, if necessary, the cylinder is tipped slightly so as to allow the liquid to flow out. In a few seconds the receptacle will be found to be full of the solid substance which may be applied by forcing a small quantity from a hollow glass tube, or a pencil may be made by hammering the solid through an ordinary funnel. As thus prepared the solid quickly evaporates, but may be kept about an hour or so if wrapped in non-conducting material.

Although there is necessarily a large amount wasted each time the cylinder is opened, yet the cost is trifling, as one of the 28 lb. cylinders will yield about a dozen days' supply.

H. FINNEMORE.

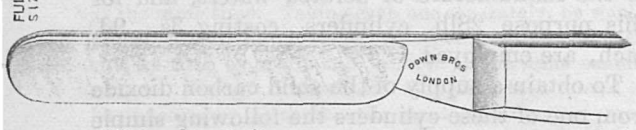
A Few Remarks on the Knife.

Whilst operating on a hygroma of the neck, it occurred to me that the point of the knife was a disadvantage, so I removed the tumour whole with a blunt-ended tenotomy knife. It was too slight for the work, so following up the idea I had some scalpels made with a blunt end, only just turning the edge up for a short distance at the end. I find it has the following advantages over the scalpel with a point:—

In the first incision of an operation the insertion of the knife cuts towards the wound instead of undermining the skin, as happens with a pointed knife, which often punctures a vessel in the situation.

In clearing an armpit of glands no vessels are punctured, though some may be cut. The result of each cut that is made can be seen; the knife reversed makes a good blunt dissector. In the abdomen the knife need not be changed for the blunt-ended scissors, because there is no point to do damage to any structure that is suddenly pushed into the field of operation, and the resulting work is neater and cleaner than that produced by the scissors.

FULL SIZE



With this knife one must cut, for to scratch is impossible.

In removing varicose veins the branches of the vessel are not incidentally wounded, as there is no point.

In the splitting operation for appendicitis the blade reversed acts splendidly for splitting the internal oblique and transversalis. Having opened the peritoneum, the knife can be inserted edge upwards, and a cut made to the right and left without any fear, as the surface towards the bowel is blunt. It would be easy to enlarge on the advantages of a blunt-ended scalpel; but I consider a point on the knife is in the way, a hindrance to quick operating, and a dangerous companion. I am inclined to doubt whether the best surgeon in existence exercises complete control over the extreme point of his knife.

I have used blunt-ended scalpels for some time now, and am very much impressed with the difference. One can work quicker, and the extra safety is most apparent.

This scalpel wants some getting used to, as the handle has to be depressed—in other words, held much as a violinist holds his bow. It must be sharp, or the operator instinctively rises on the point, which is useless, as the end is blunt. In those situations where it is necessary to cut down on one's finger, for fear of injuring some structure underneath, the knife is held perpendicularly, and the blunt end will come down on the finger whilst the cutting edge works to the right or left as the case may be.

These scalpels have been made with great care by Messrs. Down Bros. As will be seen in the accompanying sketch, they have a straight cutting edge, very slightly turned up towards the end, and the extreme end is blunt, continuous with the back.

I offer these remarks for what they are worth, hoping my deductions are right, and that others will put the knife to the test.

A. Z. C. CRESSY.

Wallington, Surrey.
April 9th, 1910.

In Lighter Vein.

The Beaney Prize in Imaginative Pathology.

For reasons which we are not at liberty to divulge, we are enabled to give below, for the benefit of candidates, the paper which may be set at the forthcoming examination for this well-known pathological plum.

1. Write out, in pathological terms, a menu for a complete eight-course biennial dinner.
2. State what you know of the diseases (if any) which have not been attributed to chronic intestinal stasis.
3. Discuss the different kinds of complements, excluding the back-handed variety of Thompson.
4. Describe in detail the new growths arising in (*a*) the organ of Jacobson, or (*b*) the vestigial fold of Marshall. Who originated the phrases (*a*) "As malignant as Hell," and (*b*) "Next, please, Bell"? What meaning do you attach to them?
5. Discuss the effect of the Rubber Boom on the elastic fibres of the lung.
6. What do you know of pathological interest concerning pathology, A. E. Boycott, pea-soup, anti-bodies (excluding Stephen Coleridge), *plat du jour*, Bell, divers' palsy (distinguishing it from divers other diseases), hardbake, Goodhart, Old Nick, Mullins' appendix, tabby cats, jumping Frenchmen, and fleas?

(None of the questions need be answered, and certainly not more than four of them.)

Q. S.

Three Cases of Strangulated Femoral Hernia.

CLINICAL LECTURE BY Mr. SYMONDS.

Gentlemen,—The presence of three cases of strangulated femoral hernia in the ward at the same time, all submitted to operation, and all doing well, affords me an opportunity of making some remarks on this subject.

Case 1.—Ellen A., æt. 33, for some years had a lump in the groin, to which she paid little attention. From time to time it enlarged, but had never been painful. Two days before admission this swelling became large and painful, and vomiting set in. She sent for her doctor to obtain relief from the vomiting, and did not think it necessary to call his attention to the swelling. Medicine was prescribed, without affording relief, and she was seen again the same evening. The vomiting continued more or less during the night, and next morning her medical man again saw her without recognising the cause of illness. In the afternoon the patient called his attention to the swelling in the groin, and he at once sent her into the hospital for operation.

On admission, the swelling was typical of femoral hernia, was tense, but not markedly tender. The bowels had acted the afternoon before *i.e.*, some thirty-six hours after the onset of strangulation. There was as yet no general distension of the abdomen. The vomited material was brown, and of a foul odour.

On opening the sac clear inodorous fluid escaped, and a small hernia, representing less than the full calibre of the bowel, was exposed. It was dark brown, but glistening. Mr. Lobb, who performed the operation, looking upon the gut as deeply injured, adopted a proceeding of considerable interest and importance. He opened the abdomen above Poupart's ligament, and withdrew the strangulated bowel from the sac after dividing the constriction. From a close and a fuller examination obtained in this way, it was considered that the bowel would recover, and that resection was unnecessary. As a protection the great omentum was wrapped round the injured gut and fixed by sutures. The abdominal wound was closed, the femoral wound drained; the patient recovered without any unusual symptom.

Case 2.—A woman of 61 was admitted on December 30th, vomiting brown foul material. As she had old bronchitis, spinal anæsthesia was employed, but unfortunately failed to produce analgesia. The part was frozen by ethyl chloride. Clear inodorous fluid escaped; the bowel, being in good condition, was returned.

Case 3.—The third case, a woman of 33, had noticed a swelling in the groin from time to time during nine months. On three previous occasions the swelling had enlarged, and was painful for a few hours. It came down and did not return; vomiting set in, and the material rejected soon became brown.

When admitted, January 1st, there was an oval irreducible swelling parallel with Poupart's ligament, and taken to be in the inguinal canal. It was also lobulated, and on this account it was thought might be omentum or a distended canal of Nuk.

On being opened the sac was empty, the bowel having returned during the manipulations of operation.

Remarks.—The recognition of a hernia, as a rule, is easy, for the patient will call your attention to a painful swelling, in which you will find the cause of the vomiting. In one of the cases you will notice that the patient ignored the swelling for two days, and in consequence nearly lost her life. The medical man neglected to look for a hernia, possibly taking the patient's word that there was no painful lump anywhere. Let me impress this aspect of the case upon you. A patient has become accustomed to the recurrence of a swelling, thinks nothing of it; or, again, may never have recognised a swelling, though a small hernia has existed. You will find this inattention mostly in the hard-working busy mothers who come into the hospital, and occasionally amongst the better classes, especially the aged. In some cases the swelling is known to the patient, but she does not connect it with the vomiting, and chiefly because it is not painful. In others, the patient is not aware of a swelling as such, and having no pain it is overlooked. You will see, therefore, the necessity, in every case of unexplained vomiting, of carefully examining the hernial openings. Sir Samuel Wilks impressed this upon us by relating the case of a dressmaker to whom he was called for vomiting, and finding a hernia, of which the patient made no complaint, sent for Mr. Durham. As Sir Samuel would conclude, "Although as a physician I have not by operation saved a life, I have more than once done so by the early recognition of danger." I was called some distance to such a case, where the hernial apertures had been carefully examined as part

of the routine investigation. However, I re-examined, and found a small strangulated femoral, unaccompanied by pain or tenderness. The patient was an aged uncomplaining lady, which partly accounted for the absence of pain. Though of some four days' duration, recovery was uninterrupted.

Again, an error may be made in overlooking the importance of a swelling because of the absence of tenderness. The patient will say that the small lump you have found has been there a long time, and she is sure it has nothing to do with the illness, and you are making a fuss about nothing. In some degree she is right, for there has been a painless swelling no doubt. It is a peculiarity of femoral hernia that the fat outside the sac becomes hard and lobulated, and feels like a piece of omentum or a lipoma. This, with the sac, is the patient's old tumour, but yet within is a small knuckle of strangulated bowel, so small that when exposed it looks no larger than the tip of the forefinger.

In any case of otherwise unexplained vomiting you must not hesitate to explore any swelling in a hernial aperture. Equally true is the necessity to explore any hernia which, though always irreducible, has become larger and harder. Never write down a hernia as "obstructed." As I have pointed out on other occasions, I do not believe in the existence of such a condition, apart from early strangulation; and I have called your attention to cases left under this most dangerous classification, with a deeply strangulated gut. However, this applies rather to the inguinal variety; and yet, as I am dealing with errors, it is perhaps wise to refer to it here. One further point upon the absence of pain: I was, some years ago, called to a woman with all the signs of a strangulated hernia. The attention had been concentrated upon an obvious and irreducible umbilical hernia, the contents of which could, however, be easily displaced, and in which there was no tenderness. A further examination discovered a femoral hernia, round which there was already œdema. Fortunately recovery followed.

Peculiarities of femoral hernia.—The strangulation of the gut is more severe than in any other form. In six hours the bowel may be black. Again, the pressure of Gimbernat's ligament leads to ulceration on the inner side of the protrusion. So that while the greater portion of the gut is still viable, and might safely be returned, some operation may be required to protect against perforation. It is more difficult to reduce a femoral hernia than either of the other common varieties, for the ligamentous structures are not relaxed by anæsthesia. For these two reasons the femoral demands immediate operation more urgently than either the inguinal or umbilical. In severity of strangulation the umbilical stands next.

The position taken up by a femoral hernia of long standing resembles that of an inguinal. In one of the cases you will notice that the incision was made along the inguinal canal on the assumption that the hernia was of this variety.

The femoral hernia turns up over Poupart's ligament, and may have its long axis parallel with this structure. This is a very common arrangement, but can, as a rule, be recognised. The swelling is rounded above, and can be moved downwards over the ligament, and no tail can be traced into the canal. On pulling it away from Scarpa's triangle it will be found to be held down, and then passing the finger tips under the swelling and from side to side you can feel a tail or pedicle coming up from the saphenous opening. This excellent mode of distinction I learnt when a student from Sir Henry Howse. At the same time the line of the inguinal canal can be made out to be free though the ring may be more or less concealed.

In cutting down upon the sac of a femoral hernia, the outside layers will be found so compressed and moulded as to resemble the sac itself. Moreover, these layers will even look serous and still further resemble the sac. The escape of fluid will settle the question, but at times there will be no escape of fluid, for the gut may be adherent to the sac. When this is suspected cut nearer the neck, when fluid will be found if there be any.

You will seldom find omentum in the sac with intestine, while the association is common in inguinal and almost constant in umbilical hernia. On the other hand, it is in this variety alone that there occurs an omental hernia completely shut off from the abdominal cavity by adhesion to the neck of the sac, the latter at the same time containing fluid. This is not a strangulated variety, and need not be further referred to here.

In a femoral hernial sac you may find the Fallopian tube. The symptoms will be sudden, with slight but not persistent vomiting, the swelling tender, but not so tense as when intestine occupies the sac. The end of the tube becomes swollen and purple. I have never seen the ovary in a femoral sac, the crural opening being too small as a rule to permit its passage.

Œdema of the skin and subcutaneous tissues, indicating septic changes in the strangulated bowel or omentum, is common in umbilical hernia and consistent with recovery without resection of the intestine. Only once have I seen this in a femoral hernia. It occurred in the patient I referred to just now as having an umbilical hernia upon which attention had been concentrated. Pus had not yet formed, the sac was inflamed, but the intestine, though strangulated some days, was viable, and was therefore returned, and the patient recovered. You will see this inflamed sac occasionally in femoral hernias, but not, so far as my observation goes, in inguinal. In umbilical, it is, as I have said, common. In a recent case of strangulated omentum, the sac was intensely congested with a good deal of hæmorrhage into the wall. The piece of omentum had, however, returned during the manipulation of examination.

Taxis was not attempted in any of these cases after admission, for it is recognised that in femoral hernia reduction can hardly ever be accomplished after a few hours' strangulation. Nor is it wise to employ the method in femoral hernia, except immediately after the descent of the bowel. Even under full anæsthesia so much less relaxation takes place than in the inguinal, or even umbilical forms, that reduction without operation is seldom effected.

It is more easy to say when taxis should not be employed than when it may be used. It is justifiable in any hernia immediately after descent, or after the first vomiting, during that period of repose which, as a rule, succeeds the initial symptoms. Every hour after this renders taxis dangerous, and more so in a femoral than in any other form of hernia.

There are a few points in the operation on a strangulated femoral hernia deserving of attention. In general, let me say that we must never decline to operate on a strangulated hernia, even in the presence of other and grave disease. In my experience it has more than once happened that others had advised leaving the patient to the pain and vomiting because of heart disease, bronchitis or dropsy,

In a bad heart case in one of our medical wards, about the year 1883, such was the position. The worst that could happen was death during the anæsthesia. This is a risk we must take in all desperate conditions, and we must not be deterred for fear of such a result. Everything being ready, and being even then a believer in the value of ether, the hernia was liberated in less than ten minutes, and the man recovered, to die later from his heart disease, but without the added distress of vomiting.

In these early days I have had, like others, many a tussle with patients and their friends, and sometimes with medical men. Nor must age deter us. Even in very old people—eighty and over—the operation, especially at the present day, does well. Nor must the want of suitable surroundings postpone operation. Often have I had to get everything ready in a private house, and operate under the poorest circumstances, with a candle for light, or a small oil lamp. Only four years ago I had to operate on an old retired medical man, in anything but suitable surroundings, and with a very poor light indeed. Valuable time would have been wasted had I delayed in making the elaborate preparations you are accustomed to see here. Strict preparation of the operating site, surrounded by towels wrung out of lotion, and a quick operation gave the best of results. You will notice that in one of the cases the bronchitis was considered so dangerous as to warrant spinal anæsthesia. This being unsuccessful, the operation was completed with local anæsthesia.

It is worth while to note that old people will bear more pain than the younger, or perhaps it is that they feel less. You can render the parts very fairly painless by injecting cocaine or novocaine. One accident is said to occur in dividing the neck of the sac in a femoral hernia, but which in over thirty-five years' experience I have not personally encountered, and that is, injury to the obturator artery. It must be caused by too free a division of the ligament. From the very first one recognised that the merest touch with the knife, enough to start a tear, is sufficient. The knife is withdrawn, and then pressure on the ligament with the director will enlarge the opening to any required extent. You will see that the merest touch of the knife is all that is required, and this is best made by a sliding movement. I once went to operate on a femoral hernia and found I had left my director and hernia knife behind. I used the blade of a pair of straight scissors; it combined a director and a cutting edge and acted admirably, and this answers very well indeed. It showed that a comparatively blunt edge is sufficient to divide the tense ligamentous margin, then lifting up the neck by any blunt instrument such as a director or a raspatory, or even the pressure of the finger, will extend the division if necessary. Usually the to-and-fro movement of the scissors blade is sufficient and free from danger. I commend this plan for your adoption, as being safer and as effective as a knife.

Once more let me say that in hernia operations our first duty is to reduce the bowel as quickly as possible; you must be ready to operate the moment the patient is under, and be content, in old people and in advanced cases, with reduction only. Such an operation even in unaccustomed hands need not occupy more than fifteen to twenty minutes, and may be done in ten. In my next lecture I will deal with the important question of how to deal with a knuckle of bowel considered too much damaged to return, and also with some points in the significance of vomiting.

Appointments.

Medical School Appointments.

The following appointments have been made by the Treasurer upon the recommendation of the Medical Council:—

Clinical Assistants in Medical Wards.—Messrs. H. W. Doll, W. E. Fox (Dr. Hale White); E. Billing, L. K. Edmeades (Dr. Pitt); A. Stanley Roe, G. C. Lowe (Sir Cooper Perry); E. P. Poulton, A. D. J. B. Williams (Dr. Shaw).

Clinical Assistant in Surgical Wards.—Messrs. H. I. Shahin (Mr. Symonds); N. A. Dyce Sharp (Mr. Dunn).

Ophthalmic Dressers.—Messrs. H. W. Barber (Mr. Eason, May 1st); G. Y. Thomson, J. Pryce-Davies (Mr. Ormond, May 1st); F. A. Dick, R. Montgomery (Mr. Eason, June 16th); W. E. Levinson, W. Reynolds (Mr. Ormond, June 16th).

Surgeons' Dressers. — Messrs. G. Marshall, H. P. Warner, G. W. M. Andrew, A. Sandison, J. L. M. Symns, L. Milton (Mr. Symonds); H. L. S. Griffiths, A. C. Jepson, R. Heaton, R. S. de C. Bennett, W. E. S. Digby, G. Covell (Mr. Lane); A. Seabrooke, F. G. Lloyd, A. H. Birks, E. W. Blake, W. S. Lacey, H. G. Crawford (Mr. Dunn); T. E. Roberts, B. R. Parmiter, P. J. Watkin, T. S. Allen, E. R. Hart, G. T. Foster Smith (Sir Alfred Fripp).

Externs.—Messrs. H. Platts, L. C. W. Cane, W. E. Levinson, H. T. Depree, L. C. D. Irvine (May); N. S. Carruthers, H. L. James, O. E. Williams, H. G. B. Blackman, A. J. Frädersdorff (June); G. T. Mullally, A. H. Gool, G. A. Blake, A. M. Bodkin, J. M. Jarvie (July).

Pathological Assistants to Surgical Registrars.—Messrs. H. L. James, N. Mutch, A. Sandison.

Student Demonstrators in Histology.—Messrs. G. S. Miller, G. E. Genge Andrews.

Student Demonstrator of Anatomy.—M. Mahon.

Nephritis.

Paper read before the Guy's Physical Society, by Mr. G. Marshall.

Mr. Chairman and Gentlemen,—The subject of this paper is "Nephritis," and more especially concerns chronic parenchymatous nephritis. I feel I owe you an apology for dealing with so vast a subject, and one in which a wide clinical experience is really necessary for its proper treatment.

Pathology of the kidneys, if dated from the time when observations were first made upon the characters of the urine in disease, is certainly the oldest branch of medical science. Moreover, it is a field in which no institution holds so high a record as this hospital, from the first clear exposition by Bright, that albuminuria was due to renal disease, to the present day, and the physiological researches of Bainbridge and Beddard, into the functions of the various parts of the kidneys separately, and of the kidney as a whole in relation to the metabolism of the individual.

With regard to nephritis, let us first see how we stand to-day in the classification and diagnosis of the various forms. The classification given by Osler is one which is accepted very generally, and one which I have heard taught in this hospital. Osler divides all cases into acute and chronic Bright's disease. With the acute form we need not concern ourselves very much. There is general agreement that if the kidneys show any change at all, they are congested and large. As to symptoms, the amount of urine is reduced, and there is usually œdema, although the latter may not occur even in the most severe cases. There is, however, still much discussion as to the etiology of the condition, and the opinion that seems to be gaining ground is that cold alone will not cause nephritis, but that, as in the case of pleurisy and pneumonia, there must be some toxic agent also present.

Chronic Bright's disease Osler divides under two main headings—chronic interstitial nephritis and chronic parenchymatous nephritis. The chronic interstitial nephritis, or true granular kidney, is seen in patients above 40 years of age; it is associated with marked changes in the arterial walls both in the kidney and elsewhere in the body. There is marked cardiac hypertrophy, and usually no œdema. It is more than doubtful whether this condition is primarily a renal one, and we will turn our attention to the other division—chronic parenchymatous nephritis.

Osler says that chronic parenchymatous nephritis usually follows acute nephritis, the main symptom is marked dropsy. If the patient dies early, one finds, post-mortem, large white kidneys. If the patient survives, however, these large white kidneys will contract and become small white kidneys. As regards diagnosis, Osler says that it may be impossible to determine between large and small white kidneys, but in cases which have

lasted several years with increasing cardio-vascular symptoms, one may safely diagnose small white kidneys.

Let us now turn back to the old classification of Wilks. Wilks classed the large white kidney as the final stage of acute nephritis; although he refers to cases in which there were no preliminary symptoms, patients suddenly developed suppression of urine and died. Post-mortem, large white kidneys were found.

Under the heading "Chronic Bright's Disease," Wilks puts promiscuously all cases of contracted kidney, whether of the small white or red granular variety. The main difference from Osler's classification, however, is the separation of small white from large white kidney. On this point the then Dr. Wilks was very vehement. He said he had never seen a case of small white kidney in which there was the least evidence that it had developed from a large white kidney. Microscopic examination of intermediate forms always showed that the granular change was the antecedent lesion, and the mixed appearance was produced by an attack of acute nephritis superimposed. Moreover, the clinical histories of the two varieties are entirely different, the large white kidney as a rule producing marked symptoms, while the granular variety is insidious from the first.

The English author who stands pre-eminent as a lucid writer on disease of the kidneys is Rose Bradford. We have done him the honour of calling a certain condition of the kidney by his name. A Guy's man, at an examination recently, was asked what he thought of a small pale kidney. He replied, he thought it was a Rose Bradford kidney. The examiner said, with a smile, that he was Rose Bradford, but he was quite ignorant of having a kidney called after him. Nowhere in his writings does Rose Bradford claim to have been the first to describe a special condition of the kidney. Like Sir Samuel Wilks, Rose Bradford does not think there has ever been a case showing small white kidneys in which there was any good evidence that they had developed from large white kidneys. He considers that chronic nephritis usually arises insidiously, and in only a few cases does it follow on the acute form. In these few cases the acute form has usually been scarlatinal nephritis.

Cases of chronic parenchymatous nephritis fall naturally into two main classes, which may be recognised both clinically and by morbid anatomy. These are large white kidney, and small white kidney. In large white kidney the main symptom is marked dropsy, there is much albumen in the urine, uræmia is only subacute. Death is often due to intercurrent inflammatory complications such as pneumonia, pleurisy, or pericarditis. Small white kidneys, on the other hand, are seen chiefly in the young, or young adults. Most give no previous history of renal disease, and certainly none of dropsy. Frequently there is no definite ill-health until the onset of the terminal and fatal symptoms. The case may run its course without the occurrence of any œdema. An occasional symptom is moderate pigmentation of the skin. Cardio-vascular changes are more marked in small white kidneys, and there is usually marked wasting The patients die in uræmic coma.

We will now consider two cases which I had the good fortune to see last year in the wards. The first is that of a man, an engineer, aged 27, admitted into the Medical wards under Dr. Shaw, for pigmentation of the skin and weakness. Patient had been healthy until three months before admission. He denied having any venereal disease, or having taken any arsenic. The first symptom had been eczema on the face, arms, and chest. He then noticed pain in the back and slowly increasing weakness. There had been no headache. On admission, patient was found to be a thin but well-developed man. There were patches of yellowish-brown pigment scattered over the whole skin area, but none on the mucous membranes. He was markedly weak. Blood-pressure was a little high, 120 mm. The heart was of normal size; rhythm was irregular. Urine was strongly acid, of low specific gravity, and contained 1·4 parts albumen per 1,000. Although repeatedly examined, no casts were ever found in it. Ophthalmoscopic examination showed the eyes to be normal. A blood-count showed slight anæmia. One of the assistant physicians saw patient, and diagnosed *Addison's disease*. Dr. Goodhart, the consultant physician, saw the patient in conjunction with three physicians of this hospital. One physician made diagnosis of *albuminuria* and *melanodermia*; another said it was *secondary syphilis*, or else *arsenical poisoning:* a third said he was only called upon to consider the condition of the skin. He diagnosed *psoriasis*, and was quite sure patient showed no melanodermia. Dr. Goodhart thought patient was suffering from *Bright's disease*. There were no casts, because there were no tubules in which they could be formed. Cardio-vascular changes were often not well marked in these cases. Their absence indicated a bad prognosis. A few days later patient had suppression of urine, he became comatose, and died. At the autopsy small white kidneys were found, weighing only 84 gms. (a quarter the normal size). There was no hypertrophy of the heart. The suprarenal bodies were normal.

The second case is that of a girl aged 15 years, admitted into the surgical wards under Mr. Rowlands for deformity of the legs and arms. Patient had been fairly healthy until a year before admission, when she became weak, and the deformities gradually developed. Patient had been seen by a physician, who thought her a cretin. Treatment with thyroid extract was continued after her admission into hospital. On admission she was seen to be short for her age. There was much subcutaneous fat, but no œdema. The skin was of a uniform dirty-yellow tint. Patient was bright mentally. The urine was clear and contained no albumen. The optic discs were normal. An osteotomy was performed in order to correct the deformity of the femurs. After the operation patient had retention of urine. A catheter was introduced and urine containing a moderate amount of albumen was obtained. Later there was suppression. Patient became comatose and died. At the autopsy it

was found that the thyroid gland was normal. Patient had a horse-shoe kidney, very small and pale, containing only a minute remnant of renal tissue. There was a slight degree of hypertrophy of the left ventricle of the heart.

These two cases aroused considerable interest, and occasioned some surprise at the time. Yet they appear to be, in many aspects, typical cases of small white kidney. In the first place, the difficulty in diagnosis; both these patients were seen by distinguished physicians, most of whom were unable to diagnose the condition. On examining the reports of cases, which at autopsy showed small white kidneys, you will find that only a relatively small proportion were diagnosed as nephritis during life; or at all events before uræmic coma was fully developed. The second characteristic point is the sudden onset of terminal symptoms. The age of these patients is also in accordance with the rule, that they are young adults. Then there is the absence of œdema, which often fails to appear in cases of small white kidney, and no doubt that is a reason why this form of nephritis is so difficult to diagnose. In neither case was there any albuminuric retinitis. That, however, is only to be expected.

Mr. Nettleship has studied a large number of cases of albuminuric retinitis, and has found it in numerous cases of chronic nephritis. In young patients, however, he says it rarely occurs with parenchymatous nephritis; he found it in only 7 of 50 cases examined. Another remarkable feature is the small amount of cardio-vascular change, and this I have found is usually the case in patients with small white kidneys, as described in the post-mortem reports.

The cause of these cardio-vascular changes, said to be so constant a feature of renal disease, has long engaged the research of experimental pathologists. In the early days Traube suggested that the hypertrophy of the heart was due to the abnormal resistance encountered by the blood in its passage through the diseased kidneys. Others replied that the blood might go another way round, and so avoid the obstruction. Gull and Sutton looked upon the cardiac and renal affections as being co-ordinated, both being due to a general arterio-capillary fibrosis. Their explanation, however, could only apply to contracted kidneys, and has no reference to the large inflamed kidneys in which cardiac hypertrophy also occurs. Their theory is still further disposed of by Cohnheim, who says he certainly has seen kidneys atrophied owing to sclerosis of their smaller arteries. These, however, are commonly in old syphilitic patients in whom precisely cardiac hypertrophy does *not* occur. He repeatedly failed to find the least thickening in the walls of the arteries and arterioles in typical cases of contracted kidney with extreme hypertrophy of the heart.

Clinical observation has shown that the rise in arterial blood-pressure precedes the enlargement of the heart. So, clearly, the rise in blood-pressure is not secondary to the cardiac hypertrophy. Increased arterial tension has been observed within the first few days of the onset of a post-scarlatinal nephritis. Friedländer found marked cardiac hypertrophy in children who died four weeks after the onset of acute scarlatinal nephritis. In adults the change takes much longer.

We have seen that the increased blood-pressure is probably the cause of the cardiac hypertrophy. What, then, is the cause of the increased blood-pressure? It was suggested that this was caused by "water-retention," that is to say, an increased volume of the blood due to the small amount of liquid excreted, what has been termed an adjustment of the water-balance at a higher level. This is discounted by the experimental fact that not by even the strongest hydræmic plethora is it possible to raise the blood-pressure above normal values.

Israel—a physiologist named Israel—fed rabbits with urea by mouth, and said he produced renal and cardiac hypertrophy. His experiments were repeated by others, who negatived his results, and impugned his veracity. Pathologists then returned to the original theory of Traube, that the high blood-pressure is due to obstruction of the arterial flow through the kidneys.

Charles Roy and Cohnheim showed by plethysmograph experiments that introduction of small quantities of aqueous solutions of common salt or urea into the blood causes a dilatation of the arterioles of the kidneys. That is to say, the presence of potential constituents of the urine in the circulation causes an increased blood-supply to the kidneys. We therefore believe that there is a compensatory arrangement, perhaps through action on the vaso-motor centre, by means of which a sufficient circulation shall be kept up through the kidneys, whatever be the vascular obstruction in them. This is beautifully illustrated by several cases in the literature of two-sided hydronephrotic atrophy of the kidneys. Owing to a pelvic growth, both ureters have been pressed on, causing hydro-nephrosis of the two kidneys. Thus, without nephritis, great obstruction has been caused to the circulation through the kidneys; and in these cases great cardiac hypertrophy was found.

Cohnheim makes the sweeping statement that he has found some cardiac hypertrophy in all cases of chronic nephritis, provided the patients were fairly robust. In those cases where he failed to find hypertrophy, further investigation showed the kidneys to be amyloid.

The importance of all this discussion is to give some clue as to any possible utility in the cardio-vascular changes.

It was Cohnheim's emphatic opinion that the high blood-pressure is protective; and it is a mistake to make any attempt to overcome it. He referred to the fact that in chronic nephritis with a high blood-pressure, the urine, although of low specific gravity, is increased in volume, so that the excretion of urea is normal. The patient then does fairly well; but if anything occurs to disturb the cardiac compensation and lower the blood-pressure, *e.g.*, a pyrexial attack, or the development of a valvular lesion, the urine decreases in amount and the patient becomes uræmic.

In order to test the accuracy of the various views on chronic nephritis, I had recourse to the reports by the demonstrators of morbid anatomy, on all cases of large and small white kidneys occurring in the six years 1903 to 1908. I wish to thank Dr. Fawcett for his permission to abstract these reports, and also the Medical Registrars for giving me access to the corresponding clinical reports.

I will now show my gratitude by criticising the arrangement of the post-mortem reports. Although a large number of cases are indexed under the headings parenchymatous nephritis, or large and small white kidneys, many of these cases, when referred to, are stated in the reports to be something of a different nature. Then, again, each demonstrator has his own classification for diseased kidneys; he frequently relies upon this classification, and omits to give the weight and naked-eye appearance of the organs. Lastly, only in a small proportion of the cases is there any report of a microscopic examination.

All these causes combine to render much of the material valueless from our point of view. The number of cases of chronic parenchymatous nephritis, in the post-mortem reports for these six years, is large. But the number from which we can draw any conclusions is small, and you may say it is too small to be of any value. As, however, these cases form two distinct types, I give them for what they are worth.

It has been stated that in eight years only one case of large white kidney has been seen in our post-mortem department.

In the index to the post-mortem reports there are given eleven cases of large white kidney for 1906. Several of these, however, cannot be admitted into a strict classification. However, with the strictest precautions, we cannot curtail the cases to less than twenty in the six years considered.

Large white kidney.—There were 20 cases. Average age was $20\frac{1}{3}$ years, only 2 cases being over 40 years of age. The duration of the illness from the first renal symptom until death was—in 8 cases less than four months; in 6 cases between four and twelve months; in 2 cases there had been acute nephritis and apparent recovery, followed three years later by recurrence of symptoms resulting in death. In one case there had been acute nephritis twelve years before, followed by recovery and absence of all renal symptoms until one month before death.

If we disregard this last case, the average duration of the disease was ten months. Albuminuria was present in all cases; œdema in all but two; all were diagnosed as nephritis before death. Death was due to uræmic coma in 10 cases; intercurrent affections in 4 cases; directly to œdema in 3 cases; exhaustion from uræmic vomiting in 3 cases; total, 20 cases. Cardiac hypertrophy was absent in 11 cases; it was well marked in only one case.

Of cases of true small white kidney, as contrasted with the ordinary granular kidney of chronic interstitial nephritis, I could collect only twelve cases in the six years. The average age of the patients was $29\frac{1}{2}$ years. The average duration of the disease, from first renal symptom to death, was $5\frac{1}{2}$ months. Three cases gave no symptoms until sudden death in coma. Of the twelve cases only five were diagnosed as nephritis before death.

A very distinguished physician, now on the consulting staff, diagnosed one girl as a case of hysteria. She died uræmic next day; her kidneys were one quarter the normal size, and contained scarce a trace of renal tissue.

Before proceeding further, I should like to note that in the post-mortem reports there is given the case of a nulliparous woman, æt. 39, who was admitted under Mr. Symonds for deformity of the long bones, attributed to osteo-malacia. An osteotomy was performed, and she died in coma next day. At the autopsy small white kidneys were found. This bears a remarkable resemblance to the case noted earlier in this paper, of the girl who was osteotomised by Mr. Rowlands for a similar condition.

Of the 12 cases of small white kidney, in only 3 was there any œdema. In none was it well marked. Albuminuria was absent in 5 cases, and was found only in trace in 3 cases. So that in only one-fourth of the cases was there any considerable amount of albumen in the urine. Death was due to uræmia in all but one case. This case died of colitis. Cardiac hypertrophy was marked in 2 cases; was slight, and affected the left ventricle only, in 8 cases. It was absent in 2 cases.

To sum up, then, we may say that large white kidneys are not so rare as some would have us believe, and perhaps small white kidneys are not so common. The aphorism about the large white man with the large white kidney is supported by these cases.

We find that the cases of chronic parenchymatous nephritis fall naturally into two main classes:

Small White Kidney.	Large White Kidney.
The average age at death in both lies between 20 and 30 years.	
Average duration of disease (1st symptom to death) $5\frac{1}{2}$ months.	Average duration of disease (1st symptom to death) 10 months.
Albuminuria and œdema rare.	Albuminuria and œdema practically always.
Cardiac hypertrophy is almost always slight; is usually present.	Cardiac hypertrophy is almost always slight; is often absent.
All die of uræmia.	Some die of intercurrent affections.

In these cases of small white kidney there is only one with a renal history of sufficient length (nine months) to make it possible that the patient could have first had large white kidneys. But even in this case the history was one of chronic insidious uræmia without œdema. So we may say that our few cases fully bear out the

contentions of Wilks and Rose Bradford as to the improbability that small white kidneys are ever developed by the contraction of the large white.

If this paper is greatly lacking in clearness, I plead that the subject is vast and confusing. I am satisfied if I have shown that some of the theories and classifications much accepted to-day rest upon contentions which are at least debatable.

Pass List.

Final Conjoint Examination, April, 1910.

Medicine, Surgery and Midwifery.

*E. P. Poulton. | *G. Y. Thomson.

Medicine and Surgery.

*F. S. D. Berry. | H. Gardiner.
*G. Dunderdale. | *G. Maxted.

Medicine and Midwifery.

*C. Witts.

Surgery and Midwifery.

R. Montgomery.

Medicine only.

H. R. Bastard. | W. Reynolds.
F. C. Endean. | A. L. Saul.
K. T. Khong. | *T. D. M. Stout.
*N. L. M. Reader. | *C. C. Tudge.

Surgery only.

*W. T. Clarke. | H. F. Renton.
*F. Kahlenberg. | *F. D. Saner.
*F. Morres. | *H. I. Shaheen.
*P. V. G. Pedrick. | *N. A. Dyce Sharp.
*A. E. Rayner. |

Midwifery only.

W. E. Fox. | E. A. Penny.
D. C. Lloyd. | R. Stout.
M. M. Munden. |

* Denotes completion of examination.

Second Conjoint Examination, April, 1910.

Anatomy and Physiology.

A. F. Camp. | A. S. Morgan.
R. B. Campion. | G. B. Pritchard.
W. K. Fry. | T. A. Townsend.
L. P. Harris. | W. C. Whitworth.
J. L. D. Lewis. | S. Wickenden.
H. L. Messenger. | O. R. L. Wilson.

Notices.

School Examination in Medicine.

The next School Examination in Medicine for admission to the Revision Classes in Medicine will be held on Monday, May 9th, in the Medical School, at 10 a.m.

HERBERT FRENCH.

Notes of Some Interesting Appendix Cases.

By PHILIP TURNER, M.S.

I have recently had occasion to operate on a number of cases of appendicitis which have shown unusual points of interest either as regards symptoms, diagnosis or complications. The following are notes of four of these cases. The cases were reported by Messrs. O. E. Williams, H. N. Eccles, W. Langdon and V. T. Webster respectively.

Case I.—Jane P., a married woman, æt. 32, about five months advanced in pregnancy, was admitted into Mary under Dr. Shaw for intense abdominal pain which had commenced about six days previously and had steadily got worse. The abdomen was everywhere rigid and tender, the maximum of tenderness being in the right iliac fossa. Appendicitis with general peritonitis was diagnosed, and immediate operation decided on. The peritoneal cavity was opened by a vertical incision in the right iliac fossa. Pus escaped freely at once, and there was apparently no attempt at localisation. The cæcum was easily reached and drawn out of the wound, and the appendix, the distal extremity of which was gangrenous and perforated, was removed and the stump embedded in the cæcum. Drainage tubes were inserted in a downward direction towards the pelvic brim, upwards towards the loin and inwards towards the umbilicus. A similar incision was made on the left side where pus was present in large quantities and in all directions. Through both incisions the uterus could be seen. Its surface was hyperæmic, and lymph was adherent in many places. A hopeful point as regards prognosis was that there was no paralytic distension of the bowel. The patient's condition began to improve almost at once. Two days later the bowels acted after a dose of ol. ric., and a week after the operation both wounds were completely sewn up. On November 8th, two weeks after admission, she gave birth to a child which, though very premature, lived for a few hours. The subsequent history was uneventful, though she was kept in the hospital for some time for joint pains and severe headaches. I saw her at Out-patients about six weeks ago and she was then in every way very well.

The chief point of interest about this case was that, though the uterus was everywhere bathed with pus and its serous coat was acutely inflamed, labour did not come on for over two weeks and that the child was alive.

Case 2.—Emily R., a married woman, æt. 32, was admitted into Charity for pain in the back and in the right side of the abdomen. The pain had been noticed for three months, and had been almost persistent, though there were numerous exacerbations. These sharper attacks were occasionally momentary, but sometimes lasted for several hours. When asked to localize the pain, the patient placed her hand immediately below the last rib on the right side, just to the outer border of the erector spinæ. The exacerbations of pain were described as shooting across the back, or as shooting downwards towards the groin. She had never been sick, but was subject to constipation. On examination, beyond some tenderness in the regions indicated above, nothing could be made out. No lump could be felt, and neither kidney nor liver were palpable. The character of the pain certainly suggested the possibility of renal trouble, but a number of examinations of the urine proved it always to be normal, and an X-ray examination failed to reveal any calculi. The patient had never been jaundiced, and there was no history of any gynæcological trouble. The first point of interest in this case was the diagnosis, and having found no evidence of renal trouble it was felt that this rested between gall-stones and chronic appendicular trouble. The absence of jaundice and presence of some tenderness in the right iliac fossa made one think the latter the most probable.

The abdomen was opened just below the level of the umbilicus by an incision through the outer border of the sheath of the rectus. The cæcum was drawn through the opening and the appendix brought into view. It was found to be very long and sharply curved, so that it was horseshoe shaped. The convexity of the horseshoe was adherent to the lower part of the ileum. At this point of maximum curvature the appendix was constricted. The part distal to this constriction was markedly dilated, and contained a large concretion which could not be forced backwards through the constriction. The appendix was removed and the stump buried. This patient did extremely well, and has since been quite free from the pain.

The condition found at the operation was one of great interest, for surely one cannot imagine a more dangerous condition of the appendix. One feels sure that in the end the concretion must have caused ulceration, perforation, and very probably a general peritonitis. The continuous nature of the pain is probably explained by the free movement of the concretion in the bulbous extremity of the appendix. The unusual localization and distribution of the pain is more difficult to explain, because the cæcum and appendix occupied their normal position.

A difficulty in diagnosis, though of a different kind, was present in the following case. The definite history of a strain causing the trouble is also of interest.

Case 3.—John N., a thin old man æt. 60, was admitted under Dr. Shaw for abdominal pain. His illness commenced nine days before admission, when, after lifting a heavy sack of potatoes, he was seized with a sharp pain on the right side of the abdomen. The pain had become more persistent and more intense. He had not been sick, though he had several times had attacks of nausea. The bowels had not acted for five days. On examination, the whole of the right side of the abdomen was rigid and tender, the left side being quite supple and devoid of tenderness. There was also a well-marked lump extending from the costal margin to just below the level of the umbilicus. This was dull on percussion, the dulness being continuous with the normal liver dulness. It did not extend backwards into the loin, and hence could not be an enlarged kidney. The temperature was 98·6, and pulse rate 100. From the amount of tenderness it was thought that there was certainly a localised suppurative peritonitis, and several possibilities were suggested as the cause of this. The position of the mass certainly suggested gall bladder trouble, but there had been no previous attacks of pain and no jaundice. The patient's age, appearance, and the history of constipation, suggested the possibility of a malignant growth in the colon as the cause of the peritonitis. Also one had to consider the possibility of a leaking gastric or duodenal ulcer, though there was nothing in the patient's previous history to suggest this trouble. The fact that the patient had previously had good health, and the sudden onset, made it most likely that one was dealing with an appendicular abscess situated at a higher level than usual.

An incision was made over the mass along the outer margin of the rectus sheath, and the peritoneal cavity was opened. The mass was found to be adherent to the inferior surface of the liver. It was surrounded by sterilised gauze, and when some thickened omentum was torn through, foul-smelling pus escaped. On investigating the abscess cavity the appendix was found. Its end was bulbous, it contained a concretion, and there was a perforation about its centre. The appendix was removed, its

stump embedded in the cæcum, and a small drainage tube inserted. Recovery was uneventful, and he was discharged in six weeks with the wound completely healed.

In the next case, pneumonia was present as a complication, and at first caused some difficulty in the diagnosis.

Case 4.—Alfred B., æt. 16, was admitted under Dr. Shaw for pain in the abdomen and chest. He had been ill for five days, and the trouble had at first been regarded as influenza. He had vomited a good deal, and the bowels had not acted well. On admission, the abdomen was rigid and tender, the tenderness being most marked in the right iliac fossa. His breathing was rapid, and there was pain on taking a deep breath. Moist râles could be heard all over both sides of the chest, and the percussion note at the left base was impaired. Dr. French saw him shortly after admission, and diagnosed both pneumonia and appendicitis, but as the pulse rate was only 104, did not advise immediate operation. However, next day, as the pulse rate steadily rose to 136, and as the rigidity and tenderness of the abdomen had also increased, it was decided to operate, in spite of the extensive chest trouble.

An incision was made in the right iliac region, and on opening the peritoneum foul pus was at once found. The appendix, which was gangrenous, was ligatured and removed. Drainage tubes were inserted and a similar incision made on the left side, where, however, there was very little pus found. The anæsthetic (open ether) was taken badly, and oxygen was freely administered during the operation. The patient lived for a week, during which time the chest trouble got a good deal worse. At the post-mortem there was a gangrenous area in the ascending colon, and pus was present all over the general peritoneal cavity. Pleurisy was present all over both lungs; the left lower lobe was solid; there were scattered areas of consolidation in the left upper lobe, and also throughout the right lung.

In this patient the question at first arose as to whether the abdominal pain was due to appendicitis or whether it was merely a symptom of the lung trouble—a point in diagnosis which not infrequently arises. Both, however, proved to be present together. In addition to marking the symptoms of appendicitis, the very extensive pneumonia was probably chiefly responsible for the fatal result.

Reviews, etc.

Books for review should be addressed to The Editor, Gazette Office, Guy's Hospital, S.E. Their price should in every case be stated.

Proceedings of the Royal Society of Medicine. (Longmans, Green & Co.) 7s. 6d.

The February number of the Proceedings contains as usual, much of interest. To the Balneological and Climatological Section, Dr. Ackerley contributes an interesting paper on the Saline Waters. He attacks his subject from the point of view of a Spa practitioner, and in a masterly way shows the ill-effects of sodium chloride, especially when taken in excess with food-stuffs.

In the Clinical Section there is a discussion on the doubtful claims of Fibrolysin, the general trend being by no means in its favour. Mr. J. E. Adams describes an admirable case of Thoracoplasty for Empyema: Mr. Herbert Tilley, a peculiar case of "clicking tic"; Dr. Weber, two cases of Chronic Arteritis Obliterans, one in which Intermittent Claudication ensued, and the second associated with Phlebitis; and Dr. Morley Fletcher, a case of Syringomyelia of Morvan's type.

Prof. Llewellyn Phillips contributes to the Medical Section an interesting account of cases of Tetanus treated by intra-spinal injections of magnesium sulphate (3–5 c.c. of a 25 per cent. solution); out of seven cases reported, four recovered. Its action is distinctly palliative, Cruveilhier's experiments showing that it neither neutralizes nor destroys the toxin.

In a paper in the Neurological Section, Dr. Mott deals with Syphilis and Parasyphilis of the Nervous System. We recommend a study of this contribution to senior students.

In the Odontological Section, Mr. Kenneth Goadby deals with the Vaccine Treatment of Early Cases of Pyorrhœa, and there then follows a discussion on the excellent paper of Dr. Eyre and Mr. Lewin Payne, which was read at the last meeting.

The Pathological Section provides interesting reading. Amongst other communications we notice two by Dr. Herbert French, one a case of extensive Fibro-caseous Disease of the Suprarenal Capsules without symptoms of Addison's Disease, and the other a case of "Diabète Bronzé."

The Medical Annual, 1910. (John Wright & Sons.) Price 8s. 6d. net.

This publication is, as usual, an excellent résumé of the year's progress in the various branches of medicine. To the practitioner who wishes to cull, at a minimum of trouble, all the latest treatment, the Annual is of the utmost assistance. Added to this, the fund of useful information on all subjects medical, from a list of the leading publications of the year to a short description of English Spas, renders the book an extremely useful addition to one's library.

The Optic Nerve and the Accessory Sinuses of the Nose. By Professor A. Onodi (University, Budapest). Authorised translation by J. Lückhoff, M.D. (London: Baillière, Tindall, & Cox.) Pp. 110. Fifty illustrations. Price 10s. 6d. net.

The study of anatomy by means of sections through frozen or formalin-hardened subjects has developed our knowledge of topographical and surgical relations to a degree which cannot be imagined by those accustomed to the old methods of dissection with forceps and scalpel only, and in no recent book has the advantage of this method of study been more amply demonstrated than in Professor Onodi's monograph, of which the volume under review is a welcome translation.

Admirable photographs, mostly life size, of numerous well-chosen sections through the head in the region of the nasal sinuses and the optic canals bring home to everyone in a most striking manner the close relationship of these structures, and the remarkable proximity of the optic nerve to the ethmoidal, sphenoidal, and frontal sinuses is only exceeded in interest by the variety of anatomical forms that may be met with in the structure of this portion of the skull.

The principal result of Professor Onodi's investigations is the demonstration that not only may the optic nerve be in the closest possible apposition to the sphenoidal and ethmoidal sinuses, being separated from these cavities by a layer of bone which is often no thicker than a sheet of note paper, but that in some cases it may even come into close contact with an enlarged frontal sinus or antrum of Highmore; and also that, owing to the great variety and irregularity in the shape and distribution of the cells, the optic nerve of one side may come into actual contact with a sphenoidal or ethmoidal sinus of the other.

The clinical importance of these anatomical facts is being recognised more fully day by day, and the literature with reference to affections of the optic nerve due to inflammation of the accessory sinuses of the nose is growing rapidly. In view of the tendency to ascribe to inflammation of these sinuses all cases of optic neuritis or atrophy of obscure origin, Professor Onodi is laudably careful to ensure that the association of sinus disease and ocular affections, in all cases he quotes, is proved beyond a doubt. For he says: "Various causes have been established by ophthalmologists as productive of optic neuritis and optic atrophy. Optic neuritis and optic atrophy may be present in disease of the nasal accessory sinuses without having been caused by it. Even in cases where the nasal origin of such optic nerve disturbance can no longer be doubted, we must still bear in mind the possibility of accidental association. Cases have been observed where the unfavourable progress of an optic neuritis was not in the slightest degree influenced by operation on diseased accessory sinuses, and, on the other hand, in cases of accessory sinus suppuration in which operation was refused, spontaneous cure of an optic neuritis that was present has been reported. Cases, too, are not uncommon in which optic neuritis or optic atrophy is in existence where the ophthalmologist can discover no cause and the rhinologist finds normal nasal cavities."

Nevertheless, all the literature on the subject having been reviewed in such a judicial manner, abundant proof is forthcoming in this volume of the occurrence of optic neuritis and atrophy, meningitis, thrombosis of the cavernous sinus, cerebral abscess, and many other orbital and intracranial affections, directly due to inflammation in the sinuses connected with the nose, and for this reason Professor Onodi's monograph, with its wealth of clinical and anatomical material, should be in the hands of every nasal and ophthalmic surgeon.

For the *format* of this edition there can be nothing but praise; the type, binding and paper are all excellent, and the photographs of the cranial sections are an education in themselves; but, at the same time, it may be permitted to enter a protest against the growing practice of quoting in the text the name of every reporter of a clinical case. In one page of the present book no fewer than thirty names occur in the space of twenty-six lines, with the most irritating effect. It is time that medical writers should follow the rule laid down by the late Lord Acton in drafting the scheme of the Cambridge Modern History:—"There would be a clean text, without footnotes or foreign quotations, or reference to particular authorities. The name of the author would be the reader's security for obtaining, without discussion or parade, the most perfect narrative that any scholar can supply, in the appointed space." Let there be a copious bibliography, but at the end of the volume.

Papers by Guy's Men.

Edwin Goodall, M.D. Lond., F.R.C.P. Lond.: An Address on Ideals in Psychiatry.—*British Medical Journal*, 16th April, 1910.

W. Sampson Handley, M.S. Lond., F.R.C.S. Eng.: Hunterian Lectures (Abstract of the) on the Surgery of the Lymphatic System (Illustrated).—*The Lancet*, 16th April, 1910.

Sir Henry Morris, Bart., F.R.C.S. Eng.: Rabelais the Physician.—*The Lancet*, 23rd April, 1910.

Wilson Tyson, M.B., B.C. Cantab., M.R.C.S., L.R.C.P. Lond.: Ossification in the Brachialis Anticus following Injury to the Elbow (Illustrated).—*British Medical Journal*, 16th April, 1910.

Books Received in the Library.— Greenwood's Physiology of Special Senses; No. 4. vol. iii., Proceedings of the Royal Society of Medicine: Braun and Lüke's Practical Parasitology; Medical Annual for 1910; Onodi's The Optic Nerve; Clay's The Nature of Cancer; The History of the London Hospital; Glaister's Medical Jurisprudence and Toxicology, 2nd edition; Blair's Errors of Refraction; Robertson's Medical Jurisprudence, 2nd edition; (Presented by Dr. E. C. Beale) Centralblatt für Laryngologie, vol. i., 1884, to 1907, 23 vols., and The Edinburgh Stereoscopic Atlas in five sections, 2 vols. M.S. Lectures of Sir Astley Cooper.

Sport.

Cricket.

The Annual Meeting was held on Tuesday, March 15th, and the following officers elected for the ensuing season: President: Sir Alfred Fripp, M.S.; Captain, 1st XI.: R. Montgomery; Hon. Sec. and Treasurer: F. C. Hunôt; Captain, 2nd XI.: M. Scott; Vice-Captain, 2nd XI: E. Rhys-Evans; Captain, 3rd XI.: C. E. Reckitt; Vice-Captain, 3rd XI.: J. L. Stewart; Committee: F. Kahlenberg, M. M. Munden, C. H. Medlock, G. W. M. Andrew, B. Sampson.

FIXTURES.—First Eleven.

May	4	W.	Trial Game	Home.
	7	S.	Beckenham	Away.
	11	W.	Surrey Club and Ground ...	Home.
	14	S.	Sevenoaks	Away.
	18	W.	Hampstead	Home.
	21	S.	Reigate Priory	Away.
	25	W.	Granville (Lee)	Home.
	28	S.	Bexley Asylum	Away.
	30	M.	Crofton Park	Home.
June	1	W.	Tunbridge Wells	Away.
	4	S.	Athletic Sports	
	8	W.	Stoics	Home.
	11	S.	The Past	Home.
	15	W.	R.A.M.C.	Away.
	17	F.	Bickley and Bromley	Away.
	18	S.	Granville (Lee)	Away.
	22	W.	Hampstead	Away.
	25	S.	... ...	
	28	Tu.	M.C.C.	Home.
	30	Th.	Forest Hill	Home.
July	1	F.	Thespids	Home.
	2	S.	Wanderers	Home.
	4	M.	Forest Hill	Away.
	6	W.	Lessness Park	Home.
	8	F.	Mill Hill Park	Away.
	9	S.	... ...	
	16	S.	Beckenham	Home.
	19	Tu.	London Scottish...	Away.

Second Eleven.

May	4	W.	Trial Game	Home.
	7	S.	Old Whitgiftians "A"	Home.
	11	W.	Virginia Water	Away.
	14	S.	Forest Hill	Away.
	18	W.	Manor House School	Away.
	21	S.	Granville (Lee)	Home.
	28	S.	Hampstead Nomads	Home.
June	1	W.	Æsculapians	Home.
	4	S.	Athletic Sports	
	11	S.	... ...	
	15	W.	Royal Naval College	Away.
	18	S.	Manor House School	Home.
	25	S.	Roving Friars	Home.
July	2	S.	Granville (Lee)	Away.
	9	S.	London and S. W. Bank ...	Away.

Third Eleven.

May	7	S.	Ewell	Away.
	11	W.	Brentwood School	Away.
	18	W.	London Hospital	Away.
	25	W.	Sevenoaks	Away.
June	4	S.	Athletic Sports	
	11	S.	Old Sennockians	Away.
	15	W.	Brentwood School	Away.
	18	S.	Ewell	Away.
	25	S.	Camberwell House	Away.
July	9	S.	Mr. W. C. Hancock's XI. ...	Home.
	16	S.	Sevenoaks School	Away.

Specialities.

The Bernard Beer Syphon.

The Bernard Beer Co., Ltd., of 60, Watling Street, E.C., and 71, Bond Street, South Lambeth, S.W., have recently sent us samples of their beers, which they send out in special syphons. These syphons are ingeniously contrived so that beer can be drawn from them in perfect condition, in any quantity, at any time; and, while preserving the essential characteristics of draught beer, the syphons provide that no contamination of their contents with air is possible, however long they are kept, so that the beer retains throughout its excellent quality. Further, by a clever device attached to the syphons, it is arranged that a constant pressure of gas can be brought to bear on the fluid inside the syphons.

The syphons are owned by the Company, who deliver them to customers, and collect them when empty. Before re-filling they are carefully cleaned and sterilised. Several varieties of excellent Lager, Guinness' Stout, and Devonshire Cyder are sent out in these syphons, at reasonable charges, and any other beers can be supplied on demand. We consider that the Bernard Beer Company's system marks a great advance in cleanliness and convenience on any other method of delivering draught beer.

Appointments.

Naval and Military.

Fleet Surgeon W. Bett, R.N., has been appointed to the Cadets' Hospital, Royal Naval College, Dartmouth.

J. Roberts, L.D.S. Eng., has been appointed Dental Surgeon, Royal Naval Barracks, Chatham.

Captain M. C. Wetherell, M.D., R.A.M.C., 7th (Meerut) Division, has been appointed Specialist in Electrical Science.

Lieutenant P. K. Tarapore, I.M.S., is promoted to be Captain.

Births.

GILL.—On February 15th, at 18, College Street, Hyde Park, Sydney, N.S.W., the wife of James Macdonald Gill, of a son.

PAYNE.—On March 30th, at "Northwood," Alton, Hants, the wife of O. V. Payne, M.B., B.C., of a daughter.

MOON.—On the 16th inst., at 45, Green Street, W., the wife of R. O. Moon, M.D., of a daughter.

PENDLEBURY.—On the 17th April, at Knowles House, Ormskirk, the wife of John P. Pendlebury, M.R.C.S., L.R.C.P., of a daughter.

Death.

RICHARDS.—On April 4th, at Llandudno, Thomas Richards, M.D. Edin., of Temple House, Bath Row, Birmingham, in his 56th year.

Ed.—A. N. C.

GUY'S HOSPITAL GAZETTE.

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King Edward the Seventh and Guy's Hospital.

WHILE all the outside world is mourning the death of King Edward as a great King, as the Peacemaker of Europe, and as a King among sportsmen, we who belong to the world of hospitals have a very special cause for grief and sorrow. For our late King was one of the best friends the hospitals ever had. He it was who inaugurated that great charitable fund, afterwards known as King Edward's Hospital Fund for London, which was founded on February 5th, 1897, to commemorate the Diamond Jubilee of his royal mother. This fund was designed to reach sources of financial help for charity which were not reached by existing funds and societies. So successful was it, that the receipts in the first year amounted to £227,552, of which £167,021 was carried forward as capital, and during 1908 the amount distributed to the various hospitals and institutions was £131,500, and the total amount of its invested funds at the end of the year was no less than £1,548,909. Guy's alone has benefited by King Edward's Fund to the extent of £91,412 during the twelve years of its existence. Apart from the actual financial help which the fund has rendered to the London hospitals, it has been a valuable agency in the equally important work of the organisation of charity, and in promoting a uniform system of hospital accounts.

But at Guy's Hospital we have particular reason to mourn, in the death of King Edward, the loss of a friend, as well as of a great patron, a loss which we share with all other great hospitals and charities.

On June 3rd, 1896, King Edward, then Prince of Wales, became our President, and on June 10th of the same year he occupied the chair at the great hospital dinner at the Imperial Institute, when he was able to announce that £156,000 had already been subscribed towards the new Re-endowment Fund which he had inaugurated.

On this day the Prince's hand was photographed by the X-rays, and the result hangs on the wall of the GAZETTE office as a souvenir of the occasion. It is dated *June 10th, 1896*,

and was thus taken in the early days of X-ray work (Roentgen's discovery was announced in 1895), when its immense possibilities as an aid to diagnosis were just dimly foreshadowed, but the place it was destined to take in therapeutics was not even guessed at.

On May 26th, 1897, the Prince of Wales opened the new Medical School buildings, and made a stirring appeal for the endowment of medical education and research by men of wealth and philanthropic aspirations:—"Let such men," he said, "once realise that money given for the purpose of medical education directly benefits humanity, and I cannot doubt that that spirit which has prompted the British people to provide by voluntary effort what in other countries is provided by the State, will prove effective in the present need."

After his accession to the throne, King Edward became the Patron of the Hospital on April 12th, 1901, and on the same day the Prince of Wales, now King George, was elected the President.

At this time, when Death has finally claimed the mortal part of our beloved Sovereign, there is a melancholy interest in recalling those two occasions—in 1871 and in 1902—when his life was in such great hazard, when Death, the "Senior Physician," so nearly triumphed, but was on each occasion vanquished by the combined forces of a strong constitution, the most unremitting care in nursing, and the best medical skill available. The history of that sudden and severe illness which in 1902 led to the postponement of the Coronation, is too well known to all to need repetition: Maurice Maeterlinck has set forth its philosophic aspects in "Death and the Crown."

So, too, the story of that great illness in 1871, when the whole nation passed through weeks of suspense and the Prince's life was again and again despaired of, has been often told. Dr. Gull, afterwards Sir William, was summoned to the Prince. It so happened that the distinguished physician had been but a few days before appointed Consulting Physician to Guy's by the Governors. It is pleasant to recall the share which Gull had in safely carrying his illustrious patient through the long and prostrating attack of typhoid. This handsome tribute appeared in the *Times* of December 18th, 1871:—"In Dr. Gull were combined energy that never tired, watchfulness that never flagged; nursing so tender, ministry so minute, that in his functions he seemed to combine the duties of physician, dresser, dispenser, valet, nurse—now arguing with the sick man in his delirium so softly and pleasantly that the parched lips opened to take the scanty nourishment on which depended the reserves of strength for the deadly fight when all else had failed—now lifting the wasted body from bed to bed, now washing the worn frame with vinegar, with ever-ready eye and ear and finger to mark any change and phase, to watch face and heart and pulse, and passing at times twelve or fourteen hours at that bedside." And after the recovery of the Prince, and after the nation had poured forth its heart in thanksgiving, Sir William Gull characteristically remarked: "He was as well treated and nursed as if he had been a patient in Guy's Hospital."

* * * * *

While the loss of King Edward is a very heavy one for the hospitals to bear, it is good to realise that in his gracious Queen, whose pathetic message to the nation has stirred the humanity in us all, we have an equally true friend and sympathiser, and one who has shown her sympathy in the most practical and valuable manner possible.

And again, it is good to realise that King Edward has left as his successor in his great office one who has shown himself to be devoted heart and soul to the work of the hospitals, perhaps the most well-worth-doing of all charitable works. At Guy's, certainly, we shall be

able to claim a staunch friend and supporter in King George V. Appointed President in the year of his father's accession, he has shown by periodical visits to the hospital that he has its welfare sincerely at heart. On our side, while we deeply sympathise with our President and our King in his sudden and terrible bereavement, at the same time we wish him a long and prosperous reign, and abundant health and strength to sustain him in the great duties and responsibilities which devolve upon him as ruler of "this blessèd plot, this earth, this realm, this England."

Passim.

OWING to the lamented death of King Edward, we have to announce a number of alterations in regard to events which have previously been mentioned in these columns. The Musical Society's concert, announced for May 11th, has been abandoned. The first dinner of the Officers' Training Corps, announced for May 18th, has been postponed until further notice. The Football Club Ball, which was to have been held on June 20th, has been postponed until the autumn. The Pageant of London at the Crystal Palace, in which a number of Guy's men were taking part, has been postponed, and the Council "hope that it may take place next year under happier auspices." Presentation Day at London University has been postponed from May 18th until November 28th. There is no change in the arrangements for the Guy's Biennial Dinner and the Garden Party and Prize Day, which will be held as usual early in July.

This year's Royal Academy Exhibition contains two portraits of special interest to our readers. On the line in Room VI., and directly in view as one stands in the Central Hall, is the presentation portrait of Mr. Cosmo Bonsor, by Mr. Herbert Draper, which is destined to hang in the Board Room at Guy's. Mr. Herbert Draper, abandoning for a time his usual subject of nymphs and other pagan personages, has produced a very successful portrait, perhaps a little too perfect from a sartorial point of view, of our popular and genial Treasurer. The other portrait is one of Sir Henry Morris, painted by Mr. W. W. Ouless R.A., and intended for the Royal College of Surgeons. This is in Room IV.

At a Meeting of the General Court of Governors held on Friday, May 6th, Mr. W. M. Mollison, M.C., was appointed Aural Surgeon, and Mr. A. R. Thompson, Ch.M., Surgeon to the newly-established Genito-Urinary Department of the Hospital. Dr. Hertz, Assistant Physician, was appointed Physician for Nervous Diseases with charge of Out-Patients. Mr. Mollison was educated at King's College, Cambridge, and at Guy's Hospital, where, after qualifying, he held the post of House-Surgeon to Mr. Jacobson, and after that gentleman's retirement, to Mr. Lane. Mr. Mollison obtained his F.R.C.S. diploma and the degree of M.C. in 1906. He has since acted as Warden of the College, Demonstrator of Anatomy and Operative Surgery, Anæsthetist, and Clinical Assistant in the Throat Department. He also holds the post of Surgeon to In-patients at the Evelina Hospital. Last year he was appointed the first holder of the Arthur Durham Travelling Studentship, and he has spent the last six months in study abroad, chiefly in Germany and Austria.

Mr. A. R. Thompson came to us from Leeds, having qualified in 1901. At Guy's he held in succession the posts of House-Surgeon (to Mr. Symonds), Medical Officer in Bright ward, Surgical Registrar, and Resident Surgical Officer, being the first holder of the last-named post. He has since acted as Demonstrator of Anatomy in the Medical School, and Anæsthetist in the hospital. He obtained the F.R.C.S. diploma in 1902, and in 1908 was the Hunterian professor, when he lectured on the "Anatomy of the Long Bones relative to certain Fractures." He is also Assistant Surgeon at the Victoria Hospital for Children. We understand that Mr. Thompson is studying on the Continent for a time before taking up the duties of his new appointment, and that he left for Paris yesterday.

MR. WINGENT'S book of drawings, which we announced a short time ago, has just been published under the title "Drawings by R.M.W." It consists of some thirty drawings in a brown paper wrapper. Many of these will be welcome as old friends to some of our readers who have seen them in the pages of the GAZETTE or as illustrations to various Christmas programmes, but we note with pleasure that Mr. Wingent has introduced a most successful new drawing as a title-page. Doubtless many of our readers will wish to possess this interesting souvenir of their days at the hospital. Applications for copies, price 2s. 6d. each, should be addressed to Mr. E. L. Martyn Lobb, the College, Guy's Hospital.

THE current number of the *Practitioner* is devoted to the subject of Constipation in all its various aspects, and a striking illustration of the attention which our staff at Guy's have given to this subject is seen in the fact that no less than four members of it have contributed articles to this special number of the *Practitioner*. Dr. Hale White writes on "Constipation in Adults;" Dr. Beddard on "Secondary Constipation;" Mr. Arbuthnot Lane on "The Operative Treatment of Chronic Constipation;" and Dr. Hertz on "The Investigation of Constipation by the X-rays." In addition, Dr. Spriggs, an old Guy's man, contributes a paper on "Diet and Constipation."

MR. LANE'S article contains such a striking tribute to the American surgeon, that it may be of interest to our readers if we quote part of it. After speaking of the scepticism with which his views have been treated by the profession in England, Mr. Lane says:—

> "That is not the attitude of our surgical friends in Canada, and in the United States. They are in advance of us in many ways in their methods of investigation. They attack any new problem very thoroughly, and do their utmost to verify every fact by personal observation, and then they determine whether there is any truth in it or not. Trouble or expense affords no obstacle to their thirst for knowledge. They are not satisfied to accept unreservedly any statement or observation, and, least of all, any opinion, and are only prepared to receive it when they themselves have either seen it or are satisfied as to its accuracy. They have no respect for so-called authority, and part with the innumerable surgical creeds which continue to control us as readily as their business men "scrap" machinery the moment a better mechanism has been devised. It is this attitude of the American surgeon that is exerting such a magnificent influence on the surgery of that country, and is, in my opinion, making them the most progressive surgical body in the world. Let us try to follow in their footsteps, and remember that the mere denial of facts that are capable of the most complete demonstration is neither the wisest nor the most scientific method of disputing their accuracy."

WE are indebted for the following paragraph to *The Reporter*, published at Ashton-under-Lyne:—"In consequence of the plain speaking of Dr. Barnes, M.R.C.S., L.R.C.P., of Dinas Powis, South Wales, when before the Ashton-under-Lyne Board of Guardians on Thursday, as one of three selected candidates for the post of medical officer at the workhouse hospital, the Board have deferred making the appointment, and have left the matter to be dealt with by the hospital committee. Dr. Barnes had hardly taken his seat in the board-room when he intimated that he would not accept the appointment if it were offered to him. He said he had been over the hospital, which was a magnificent institution, but the system of organisation was 'scandalous and rotten in the extreme.' He could proceed no further because of the scene which followed, and during the squabble he quitted the room. Dr. Barnes has since been interviewed by a local newspaper representative. He states that for a salary of £150 he was expected to look after 300 beds under an outside medical superintendent, who was paid £100 a year, and with no dispenser or assistant. He was also to look after the lunatics. There was no system of bed cards, and no record kept of the history of the patients. The hospital was under the control of the master. When an operation was to be performed the outside medical superintendent called in an unpaid medical assistant. The superintendent was paid 10s. 6d. for each midwifery case, though the resident officer did the work. The resident medical officer was waited upon at his private table by a pauper girl inmate. Dr. Barnes was

trained at Guy's Hospital, and was recently assistant at Poplar and Stepney Sick Asylum."

SLOWLY, but surely, a more liberal-minded attitude towards the education of women is pervading University and examination authorities. Even at Oxford the other day we see that it was decided in Congregation, by a majority of six to one, to set up a new delegacy for the supervision and control of women students, in spite of the opposition of the President of Corpus, who proclaimed the danger of allowing the University to fall under the influence of women, and then knocked the bottom out of his argument by admitting that the influence was "beneficent and genial." In the world of medical education, it is worthy of note that the recent examinations for the Conjoint diploma were the first to which women were admitted. One woman candidate entered and passed; in some of the papers containing the result there is appended the very necessary footnote that "in this list the student named Dossibai Rustomji Cowasji Patell is a woman." Furthermore, we see that our contemporary, the *London Hospital Gazette*, even anticipates the day when women students shall be admitted to the London Hospital. At Guy's we refrain from such anticipations—feeling that "sufficient unto the day, etc."

WE are requested to call the attention of old Rugby Football Blues to the fact that a meeting will be held, under the new rule passed at last year's General Meeting, on Wednesday next, May 18th, to nominate the captain and secretary of the club for next season. The meeting will be held in Mr. Mullins' room in the College. The nominations afterwards come before the General Meeting held during the summer.

From the Gazette's Special Pathologist.

ALL specimens—particularly those of solid tissues—should be accompanied, if possible, by a short clinical and post-mortem history, and a postal order for 2s. 6d. An extra charge of 6d. per slide is made when prepared sections are to be forwarded.

Specimens, Letters, and Postal Orders should be addressed to the MANAGER, Gazette Office, Guy's Hospital.

M., CLACTON-ON-SEA.—Smear preparations show some cellular detritus with some micrococci, including streptococci. Media inoculated show fair numbers of streptococci having long chain formation with a few white staphylococci, no Klebs-Loffler bacilli are found on the blood serum medium.

H. J. H., AMERSHAM.—This growth is a carcinoma of the skin of the rodent ulcer type. It is composed of branching epithelial masses arising in the deepest layer of the epidermis and invading the corium.

H. J. H., AMERSHAM.—This is a simple adenomatous polypus of the cervix uteri. It is composed of a very vascular stroma with enlarged mucous glands, some of which are forming cysts. It is deeply congested and hæmorrhagic, probably the result of strangulation of its pedicle.

PATHOLOGIST.

Appointments.

Civil.

CURRIE, OSWALD JAMES, M.B. Lond., M.R.C.S. Eng., has been appointed Honorary Visiting Surgeon to the Wynberg Hospital, Cape Town.

ELLIS, ROY, L.D.S. Eng., has been appointed Dental Surgeon to Messrs. G. Cozens & Co., Edgware Road, W.

TUBBY, A. H., M.S. Lond., F.R.C.S. Eng., has been appointed Honorary Consulting Surgeon to Christ's Hospital.

Naval and Military.

Fleet Surgeon E. P. Mourilyan, M.B., R.N., has been placed on the Retired List, with permission to assume the rank of Deputy Inspector-General of Hospitals and Fleets, April 25th.

Surgeon G. F. Syms, R.N., has been appointed to the *Exmouth*.

Lieutenant M. Leckie, R.A.M.C., has arrived in Egypt for a tour of service with the Egyptian Government.

Territorial Force.

For attachment to a Unit other than a Medical Unit—Lionel Henry Moiser to be Lieutenant (dated March 11th, 1910).

Papers by Guy's Men.

Norman H. Pike, M.B., B.S. Lond.: A case of Cerebro-Spinal Rhinorrhœa with Double Optic Atrophy.—*British Medical Journal*, 7th May, 1910.

R. P. Rowlands, M.S. Lond., F.R.C.S. Eng.: Sigmoiditis and Meso-Sigmoiditis (Illustrated).—*The Lancet*, 30th April, 1910.

E. I. Spriggs, M.D. Lond., F.R.C.P. Lond.: Diet and Constipation.—*The Practitioner*, May, 1910.

W. Hale White, M.D. Lond., F.R.C.P. Lond.: Constipation in Adults.—*The Practitioner*, May, 1910.

Three Cases from Shadwell Hospital.

BY H. B. CARLYLL, M.A., M.B., B.C.

A Case of Sudden Death following Exploratory Tapping of the Chest.

In *The Lancet* of November 6th, 1909, there appeared an article by Dr. Horden, advocating the operation of putting a needle directly into the lung for diagnostic purposes in certain cases. This elicited a letter in reply from Dr. Russell and others, in which the dangers resulting from such an operation were put forward. References were given by Dr. Russell to most of the cases recorded in recent years, in which death, immediate or delayed, had occurred in association with exploration of the chest, being apparently directly attributable to puncture of the lung by the needle.

In some of these cases death may have been caused by hæmorrhage, but it is probable that the majority of fatalities are due to cardiac inhibition, following stimulation of the pulmonary fibres of the vagus.

The sudden termination of an operation, so commonly performed, is dramatic in its unexpectedness, and it may be that the operator will at some time be thankful for the memory that such a risk exists. It is for this reason chiefly that the following notes are recorded :—

L. W., a little girl aged 2½ years, was admitted to the East London Hospital for Children on April 20th, 1910, suffering from lobar pneumonia.

On admission the temperature was 101°; pulse, 152; respiration, 62. There was a large area about the angle of the right scapula, at which bronchial breathing and bronchophony were heard. At the right base the air entry was diminished, and the note impaired. Two days after admission the note at the right base was more impaired, and a diagnosis of probable empyema was made by the visiting physician. The child remained very ill. The same afternoon a needle was inserted. The child was lying in bed upon her left side; no anæsthetic was used. The child did not seem to mind the puncture of the needle. Nothing was withdrawn into the syringe, and as soon as the needle was taken out, which was done immediately, and while the patient was being gently turned on to her back, she suddenly collapsed. The face became very pale, the radial pulse completely disappeared, and the respirations, which were slow and gasping, almost immediately ceased. The usual stimulants were at once given, and ether was injected into the heart. Forcible stretching of the anal sphincter was tried, but it was found already relaxed. Some recent blood was observed on the tongue. Artificial respiration was performed for fifteen minutes, but with no effect. I greatly regret now that no attempt to restart the heart's action was made by massage through the diaphragm. A striking instance of the success of this method in some cases is related by Dr. Rutherford in the *Lancet* of April 30th, 1910.

At the autopsy held the following day, the following condition was present: The lower and middle lobes of the right lung were solid. The pneumonia was most marked at the apex of the lower lobe. There was no fluid between the pleural surfaces, but some thick flakes of lymph were seen on the diaphragmatic surface of the right lower lobe. A small but definite area of hæmorrhage was seen on the surface of the lung corresponding with the puncture wound on the chest wall. There was no blood in trachea, bronchi or stomach, but blood-stained mucus was expressed from the lung tubes. The thymus was not enlarged, nor was there any evidence of status lymphaticus. The heart was not apparently abnormal, with the exception of some slight dilatation of the right side.

Complete Transposition of Viscera, with Malformation of the Heart.

L. A., aged 4 months, was admitted to the Children's Hospital, Shadwell, on October 27th, 1909, for wasting and cyanosis. The wasting had started at 8 weeks old. There had been some cough since birth; this had been worse during the past six weeks. The cough had always been associated with cyanosis. The child was born at full term, and had been breast-fed. The parents had one other child, which was healthy.

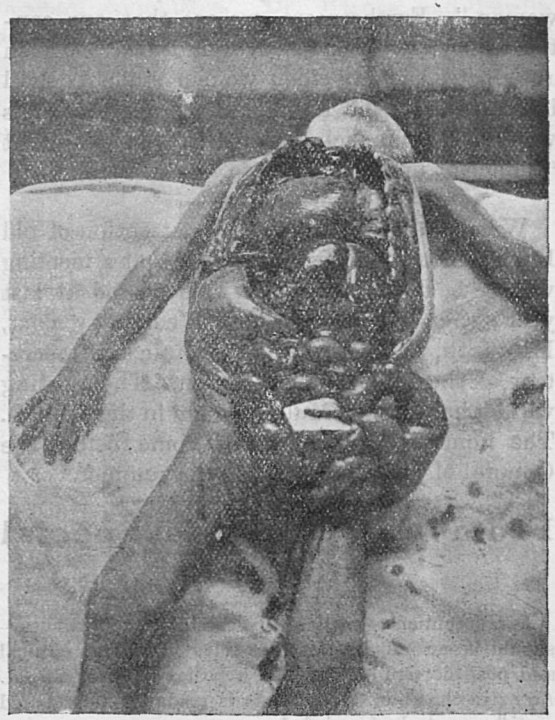


FIG. I.—Showing transposition of each viscus. A piece of paper has been placed beneath the appendix.

On admission, the child was found to be rather thin and very cyanosed. Temperature 97°, respiration 60, pulse 120. The eyes were very prominent. The anterior fontanelle was widely open, and somewhat depressed. The veins on the scalp were congested. The chest was narrow, and there was considerable recession of the epigastrium and rib spaces during respiration. The child was much troubled by a cough. The note over the lungs was good. Râles and rhonchi were heard all over. The heart apex was found in the fourth right space, just internal to the nipple line. The left border of the heart was three-quarters of an inch to the left of the middle line. A loud systolic murmur was audible at the base of the heart, and on the right side of the sternum. The second sound was accentuated. The sounds were spaced almost as in the adult type, with considerable increase of space after the second sound. The liver was also found to be transposed, being two fingers' breadth below the left costal margin, the lower border joining the right costal margin at its junction with the right mid-sternal line. Some improvement was noticed in the child's condition for a few days, but on November 1st the cyanosis increased, and the respirations became more rapid. Death occurred on November 2nd.

The autopsy revealed a complete transposition of viscera, which is well shown in the accompanying photograph, fig 1. The lungs had each three lobes, and showed much bronchitis. In the heart, the interventricular septum was shown as a small buttress, springing from below. The ventricles showed an almost common chamber. A common artery divided into the aorta and pulmonary artery, about an inch above the semilunar valves. The right auricle was very small; the left correspondingly large. The aorta arched to the right of the vertebral column.

A Case of Uraemia in a Child of Six.

T.R., a little girl of 6 years old, was admitted to the East London Hospital for Children, under Dr. Coutts, on February 21st, 1910, for dyspnœa on going upstairs, which had existed for two weeks. The history was that the child had not been well since measles, which she had in October, 1909. She had been sick, especially at night, and had been getting very pale. There had been hoarseness at times. On the day of admission she had had what was thought to be a fit. The face and arms twitched and she could not stand. The neck became swollen. The bowels had been regular. The only other previous illness had been chicken pox.

On admission.—Temperature 98·4°, pulse 130, respiration 32. The face was puffy, the cheeks pale. The lips were rather blue. The respirations were noisy and the alæ nasi muscles were contracting. There was no œdema of the legs, and the child was in no pain. The tongue was thickly coated. The apex beat was one inch outside the nipple line in the 6th space. There was some cardiac dulness to the right of the sternum. Over the mitral area a faint presystolic murmur was heard leading up to the 1st sound, which was followed by an accentuated second sound. The air entry into the lungs was good all over, but expiration was prolonged. Many rhonchi were heard, but no râles. The abdomen was rather distended. The liver was tender on palpation, and the edge was felt two and a half inches below the right costal margin.

A fair amount of urine was passed on admission. It was very light coloured and the specific gravity was 1010. It contained a large quantity of albumen. Many casts, chiefly hyaline and granular, were found. No epithelial casts were seen. A diagnosis of uræmic asthma was made; calomel and jalap were ordered and acted well. A hot-air bath was given on admission and the following day, but with no effect. Continuous inhalations of steam were also prescribed, and pilocarpine injected.

On February 23rd the child seemed better. The bowels were opened twice. The face was still puffy, but the breathing was easier. Nine ounces of urine were passed during the day. The previous day twelve ounces were passed.

On February 24th the child's condition became much worse; the breathing was very distressed. Eight or nine ounces of blood were removed from the basilic vein, and two pints of saline put under the skin. There was no response to a hot-air bath. An enema produced a good result. At 8 o'clock p.m. the face was seen to twitch, and continued to do so off and on; consciousness was gradually lost, and death occurred in coma in the early hours of February 25th.

The post-mortem examination showed some atheroma of the mitral valve. The spleen was large and very soft. The liver was large, but apparently normal. The kidneys were very small and greyish-white in colour. On section, the structure was found to be quite obliterated to the naked eye. The surface was granular, and the capsule stripped off readily. The vertical measurement of the kidneys was just over two inches, against the three and a half inches of the normal kidney of the same age which was taken for comparison.

A Noble Animal.

THE Indian pig is reputed "the pluckiest brute God ever made," and, as such, is worthy of the chase; but in ugliness, also, he is supreme, if only when, spear-point missing him, a Charybdean shock betokens Dukker's impact with horse's quarters. For here he goes by the name of Dukker, clearly a misnomer for one whose attributes are stamped with superlatives, all save domesticity. For when was Dukker tamed? Certainly not now, as with Sultan pomp he basks in noonday shade, a haremic bodyguard around, watchfully suspicious of leafy rustle in this castor-oil field, where lordly master, glutted Ciacco-like, with goodly roots and river water, wherein he, wallowing, has drunk deep, 'neath Morpheus' screen and canopy of Ricinus, seeks calmness of repose.

And for a time, well lulled; or, as when Prince Siddârtha viewed his land,

"All the jungle laughed with nesting-songs,
And all the thickets rustled with small life
Of lizard, bee, beetle, and creeping things
Pleased at the spring-time. In the mango-sprays
The sun-birds flashed; alone at his green forge
Toiled the loud coppersmith; bee-eaters hawked,
Chasing the purple butterflies; beneath,
Striped squirrels raced, the minas perked and picked,
The seven brown sisters chattered in the thorn,
The pied fish-tiger hung above the pool,
The egrets stalked among the buffaloes,
The kites sailed circles in the golden air;
About the painted temple peacocks flew,
The blue doves cooed from every well, far off
The village drums beat for some marriage-feast."

And did Lord Buddha walk the earth to-day, now as then, he would have sighed,

"I' the brake how fierce
The war of weak and strong!
I' th' air what plots!
No refuge e'en in water."

For, hither, from river-bed, Bejel, the hunter, who, in khaki coat, thinks to pass superior to his promiscuous army of underlings, beaters, coolies and tree-perched watchers, whom he musters masterfully—Bejel, who forgets three feet of chocolate legs, exposed 'neath swathing loin-cloth, thinking alone of ancestor's prowess in the chase, has, with beady eyes, undeceived by lighter female tread, tracked out our Sultan, from signs invisible to us, in sandy sun-parched soil.

And soundly Sultan sleeps, for herbal feast and mid-day heat have ta'en their toll, nor hears the stealthy slink away of faithless bodyguard, nor the hushed voices of four riders approaching furtively. "There they go at the top end!" "All sows in that party!" "Bejel playing the fool as usual!" "There he is, look out!" for by a flash of dread presentiment "helmless dreams" are swift-directed action, and sleep-baulked Sultan in rage-projected charge, meets that dark object looming near. A spurt of red, but not from Dukker's side, for the terrified waler, with an ill-timed rear, raising spear-point over that mud-coated back, receives the inevitable upward thrust of those ever-sharpened tusks, and horse and rider roll together.

There is no "winding horn," no need of summoning whistle, but how like "loud halloa" that shout from Bejel's gang; but luscious far more than all to huntsman's heart is that deep grunt of savagery which giving, Circe's triumph flees; less so to three ponies' ears, who prime an instant, then pursue. Down, then up, Sultan bobs, a grizzled dolphin in that sea of green. Two seconds more the cactus hedge is reached, through whose columned thickness, armed with bearing thorns, dense almost to impassibility, that bristling hide is torn to breathing space beyond, while pursuers seek a gap. Away across those shimmering fields, like pond'rous Dreadnought, which, appearing to tarry, space devours apace, Dukker evades baffled spear, here by cunning dodging, there by piercing a track of untilled jungle, whence startled deer radiate, to again return with returning peace, partridge and quail whirr their short flight to skim to earth beyond, while underneath the unnoticed hare tremblingly slinks away; and overhead, in thorny bush, the gentle dove flickers in and out, and Koil key-note remembers not, nor seven sisters' strife.

And, far behind, the crew of Bejel ever press on in scattered disarray, now with the sound of tom-tom, now with ardent throat, unheard, still cheering on the fray, while, last of all, chewing stout thorns, the camel strides, whose dripping load suggests the ice-cooled drink. And the sleepy ryot slowly responds to quick-directed query, scarce turning head to look.

But what of the quarry? Whither wend those tottering steps? Oh! foolish Dukker, dost thou not see yon babul brake but two short fields away? Knowest thou not that low-hanging babul-branch daunts most thy vile pursuer, nay, at times sweeps steeds back bare of wish to take thy life? But no, he is by devils fast bestrid; twin-demons Thirst and dire Fatigue hold him in base entwine, and steer far from salvation almost sure, for, where he erst did find refreshment, now destruction looms. Over the edge, down the steep steep, rolling, panting, reeling to glorious cooling flow, but, alas! never to drink; two "spume-flaked" Arabs, nimble as young doe, and spur remembering, clamber down sandy slope, which, crumbling, scarce foothold affords, and from brief wallow, strength-spent Dukker turns at bay, and then, in futile charge, that trembling frame is checked, transpierc'd by one keen lance, then two, from whose nether points the coloured stream swift drips to mingle with the swirling mud, which vainly tries to drown the ever-rising crimson; and, from fierce, shaggy visage, a convulsing shudder passes back, ere final sink to earth, and two belated horsemen gallop up to find that Dukker, too, has "perished in the waters."

And, while burning hoofs are cooled, and wiry coolies bear dead weight, suspended, trotters upward, from swaying pole, back over "land of sand and thorns" to rendezvous, there to preserve that grim mask to serve as trophy over oft-passing wine and reminiscent tale, and then to feast 'mid shades of evening, making joy o'er Dukker's fall, hoping by eating strength that strength to them may come, and, while Bejel triumphant, is enriched for trusty services, who will deny that this last struggle hath not been in vain; that, from facing danger joyfully in sport, stout spirit stouter still becomes, and that the pluck of "pluckiest brute," from funeral pyre, arises death-born in the hearts of those who choose hard riding 'neath a torrid sun, to luxurious ease under cool bungalow roof.

"Poor vaunt of life indeed,
Were man but formed to feed
On joy, to solely seek and find and feast:
Such feasting ended, then
As sure an end to men;
Irks care the crop-full bird? Frets doubt the maw-crammed beast?"

G. S. MALCOMSON,
(Capt., I.M.S.)

Diseases of the Eye caused by Inflammation of the Accessory Sinuses of the Nose.

CLINICAL LECTURE BY HERBERT L. EASON, M.D., M.S.

GENTLEMEN,—The subject of to-day's lecture is one of comparatively recent importance, having received anything like detailed attention only during the last five or six years. You know that the eye and the optic nerve in the orbit are extremely well protected in one sense, in that they are surrounded on all sides by bone, and you also know that the walls forming the orbit are not so heavy as they might be if they were solid bone, but lose very little of their strength and gain much in lightness by containing air cavities. The eye, except on the outer side, is practically surrounded by air-containing cavities in bone. The external wall of the orbit is formed by the malar bone, which is solid, but the roof of the orbit is formed by the frontal bone, in which there is the frontal sinus, which may be either a very small air space, or in some cases run back almost to the apex of the orbit, so that the orbit itself has a double roof—two thin layers of bone separated by air. The inner wall of the orbit is formed by the lacrymal bone, which is almost as thin in some places as a sheet of note-paper, and the greater part of the inner wall of the orbit is formed by the os planum of the ethmoid, which separates the orbit from the anterior and posterior ethmoidal cells. You know also that the floor of the orbit is formed by the superior maxilla, which contains the largest of all the air cavities, the antrum of Highmore. As a result of the association of these air-containing spaces with the orbit, the eye is particularly vulnerable in affections of these various cavities. All of them communicate with the nose; into the posterior part of the roof of the nasal cavity there opens that single or bilateral cavity, the sphenoidal sinus, which, though not in exact relation to the orbit itself, is in very close relation to the optic nerve as it passes through the optic foramen. The posterior ethmoidal cells open into the superior meatus; into the middle meatus the frontal sinus opens by means of the infundibulum; and the anterior and middle ethmoidal cells also open into this meatus, as does the antrum of Highmore. The lacrymal sac opens by means of the lacrymal duct into the inferior meatus of the nose. These cavities, therefore, being all in close relationship with the eye, and the optic nerve in the orbit or in the optic foramen, and all being liable to distension or suppuration as the result of acute inflammation of the nasal passages, are in some cases a source of very great danger to the optic nerve and the eye itself. The anatomy of this region is of great complexity, and it has been dealt with in a most masterly fashion in the last few years by Professor Onodi, of Buda-Pesth,* who has, by means of his anatomical researches, shown of what great importance these air sinuses are, and into what close and varied relationship to the orbit and the optic nerve they come. I propose, therefore, to preface the lecture by showing some lantern slides taken from Professor Onodi's book.

Fig. 1 is a formalin preparation showing the position of the chiasm and the course of the left optic nerve up to its entry into the globe. In its course the optic nerve touches the left sphenoidal sinus. The preparation also shows the ethmoidal cells, the frontal sinuses and the cavity of the nose.

The ethmoidal cells are, as a rule, mediolateral in relation to the two optic nerves, and unless the frontal sinuses and the antrum of Highmore are very large, or penetrate far backwards, they do not come into very close contact with either the globe or the optic nerves, being separated by the orbital fat and the orbital contents.

Fig. 2 is a coronal section showing the general relation of the nasal cavities and the meatus to the antrum of Highmore, and these posterior ethmoidal cells. Notice the close connection between the two optic nerves in the optic foramina and the posterior ethmoidal cells, from which they are separated, in many cases, by a layer of bone almost as thin as a sheet of note-paper. The entrance to the sphenoidal sinus is seen at the posterior part of the superior meatus.

Fig. 3 is a sagittal section showing how one of the ethmoidal cells almost overlaps the optic nerve itself just in front of the chiasm. It is not only in inferior relation to the optic nerve, but also in anterior relation, for it spreads a little over the top of it. The sphenoidal sinus in this case is comparatively small, and is separated from the optic nerve by the unusually large posterior ethmoidal sinus.

* Der Sehnerv und die Nebenhöhlen der Nase. By Professor A. Onodi, Wien und Leipzig, 1907. (Recently translated into English; *vide* Review, GUY'S HOSPITAL GAZETTE, April 30th, 1910.)

Fig. 4 is another section, also sagittal, showing a very large sphenoidal sinus on the left side, and a comparatively large posterior ethmoidal sinus. In this case the posterior ethmoidal sinus forms practically the whole of the anterior relation of the optic sulcus or groove on the sphenoidal bone, so that this right posterior ethmoidal sinus has even come into relationship with the left optic nerve; and this condition is a very important one, because it may explain some cases, which have been described, in which disease of the nose on one side has caused some affection of the optic nerve on the other side.

Fig. 5 is a coronal section showing the two sphenoidal sinuses, of comparatively normal size, one on either side of the middle line, separated by a thin septum. And here you see the optic nerve quite close to the sphenoidal sinus, on its outer side. Here also is a very long frontal sinus going far back, and coming into very close relationship with the optic nerve, almost at the apex of the orbit.

Fig. 6 is a horizontal section, showing great asymmetry of the sphenoidal sinuses; the left sphenoidal sinus is quite small and laterally placed.

Fig. 7 is a coronal section, showing great asymmetry between the sphenoidal sinuses on the two sides. The right sphenoidal sinus comes into direct contact with the left optic nerve.

The illustrations here shown represent only a small selection of the variations, for, as a matter of fact, Professor Onodi, with Continental thoroughness, has found that there are ten distinct anatomical groups in which the relationship of the sphenoidal and ethmoidal cells to the optic nerve is different, and he finds those subdivided into thirty-eight different groups; but all I want you to remember is the close and the varying relationships of the frontal sinus, ethmoidal cells, and sphenoidal sinus to the optic nerve, and the fact that these air-containing spaces, which are very liable to septic inflammation, are separated from the optic nerve in many cases by only a thin layer of bone; and also the very important fact that owing to the great variety in size and shape of these sinuses, the right ethmoidal and sphenoidal sinuses may come into close relationship with the left optic nerve, and *vice versa*.

Affections of the Eye as a result of Distension or Suppuration of these Sinuses.

Proptosis.—The first condition I shall mention is that of proptosis, which may be well marked on one or both sides. To illustrate this I will refer to the case of a patient who was in the Eye ward less than two years ago, with a very pronounced proptosis arising from dilatation of the ethmoidal cells.

F. W., aged 62, admitted for proptosis of left eye, 22nd January, 1908.

Previous history.—Nasal polypi had been removed from the left side of the nose on three separate occasions, when she was between the age of 7 and 12.

History of present complaint.—On the 17th January, 1899, Mr. Higgens saw patient at Out-patients. She had proptosis, and the eye was pushed downwards and outwards. Diplopia was present and most marked on looking up and in. There was a firm irregular swelling coming forwards beneath the upper margin of orbit from near the middle to the inner angle. On the 14th February, 1899, the swelling had diminished, and had been accompanied by a discharge from the left nostril. During the next few months the swelling increased in size again, diplopia was worse, and there was pain beneath the left eye-brow. In July, 1899, the swelling was incised, and some thick dirty yellow substance escaped. The examining finger detected bare bone, and an irregular opening from which a quantity of the muco-pus was evacuated. Mr. Higgens thought there was a connection with the frontal sinus. When the patient was discharged the sight was normal, and the eye had very nearly gone back into position. The patient remained in this state until July, 1902, when the eye became prominent again. On examination, it was found that the upper margin of the orbit was thickened and hard, but not bony. This protrusion of the eye diminished after about three weeks. In October, 1905, the eye was again proptosed, but it went back in a few days. The eye has been gradually coming forward during the past three months, and the patient has been having considerable pain over the frontal region.

Examination on admission.—The left eye is proptosed outwards and downwards. Its movements are limited, especially in an upward direction, and patient complains of pain on looking outwards. The left supra-orbital margin is more prominent than the right, and beneath its inner half a swelling is to be felt which extends downwards into the orbit for about half an inch. The swelling is hard, but not of bony hardness, and it does not pulsate. There is some ptosis of the eyelid.

The patient complains of diplopia except when looking downwards and outwards. The corneæ are clear, the anterior chambers are normal,

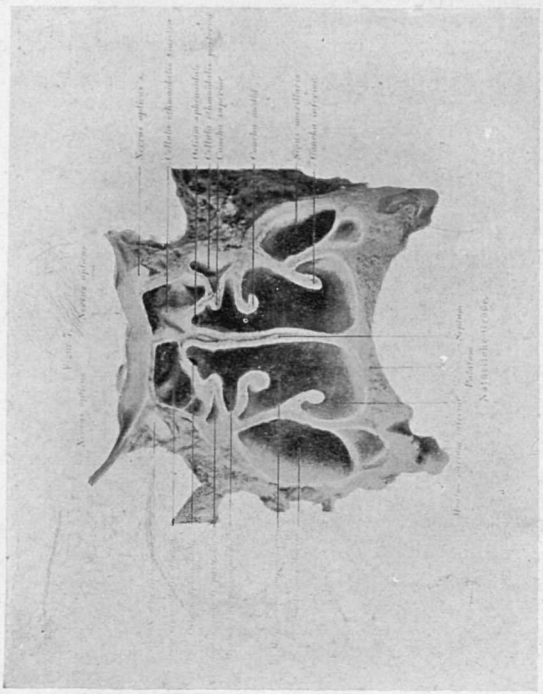


Fig. 2.

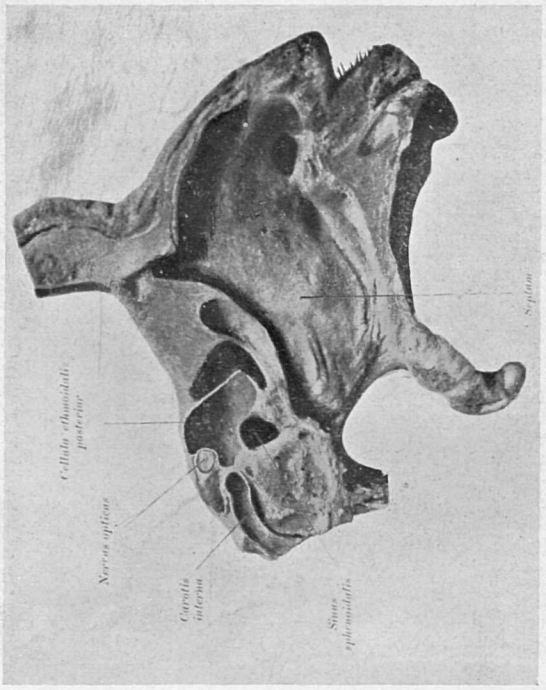


Fig. 4.

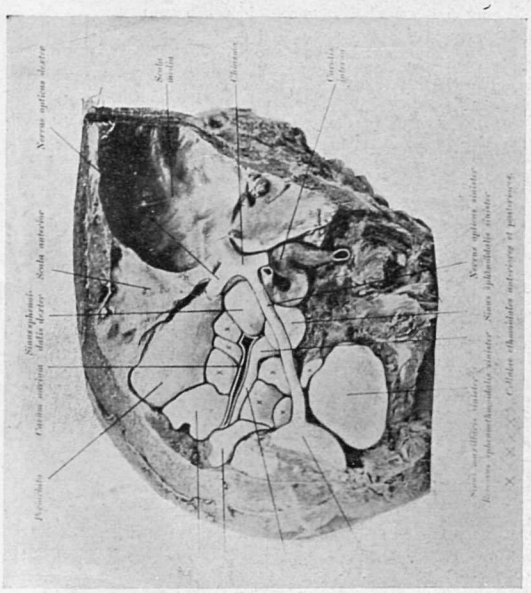


Fig. 1.

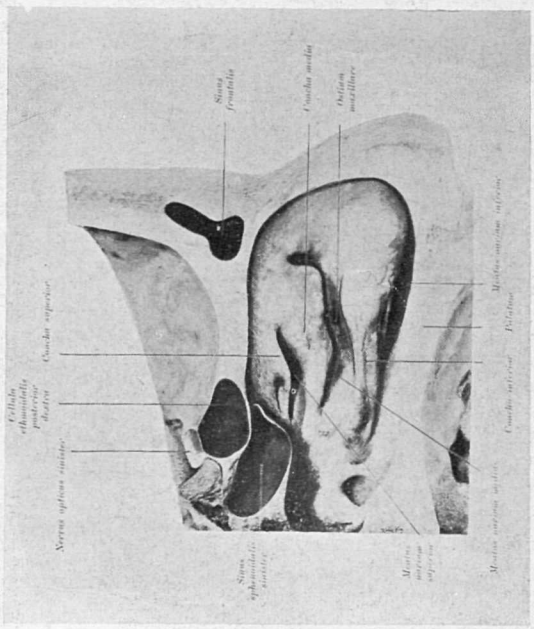
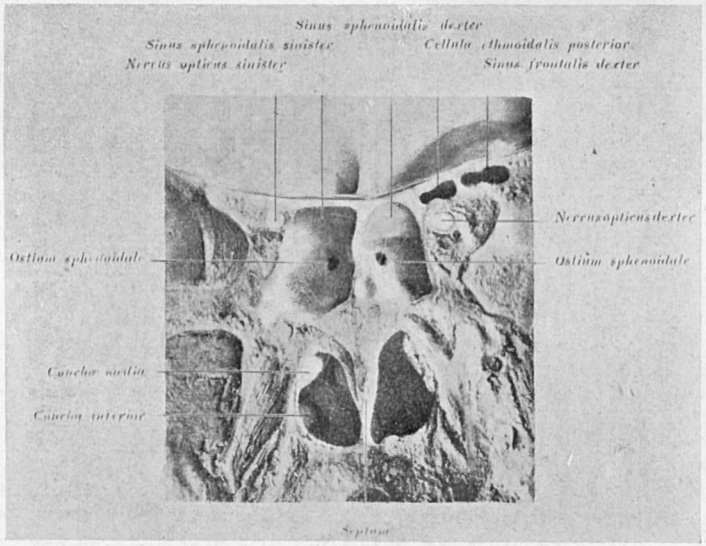


Fig. 3.



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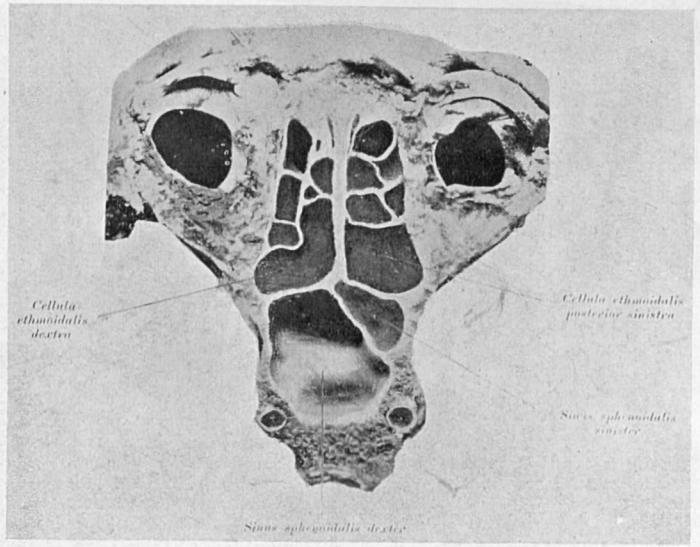

FIG. 6.

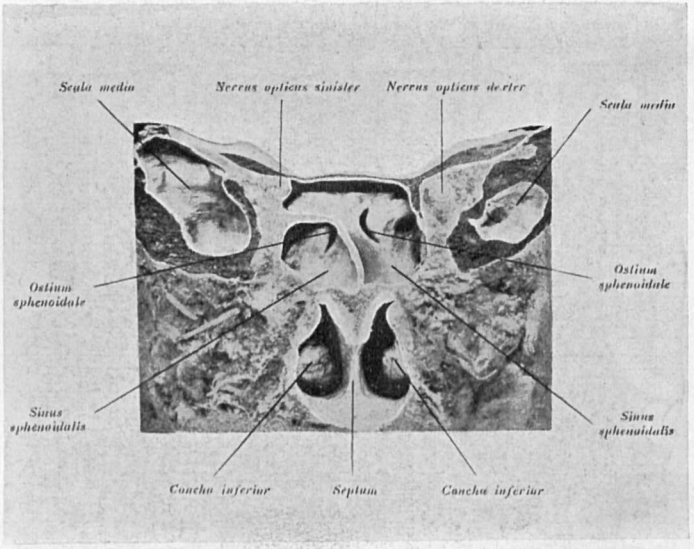

FIG. 7.

FIG. 8.

Figures illustrating Mr. Eason's lecture on "Diseases of the Eye caused by Inflammation of the Accessory Sinuses of the Nose." For permission to publish Figs. 1 to 7 we are indebted to Messrs. Baillière, Tindall & Cox, who have recently published the authorised English translation of Prof. Onodi's monograph.

the pupils react to light, and there is a good fundus reflex in each eye. There is no optic neuritis present.

Vision R.E. $\frac{6}{12}$ L.E. $\frac{6}{12}$

January 23rd, 1908. The patient was skiagraphed. The skiagram suggested that the left frontal sinus was enlarged.

January 30th, 1908. Mr. Steward saw the patient. He stated that the nasal cavities were normal, and considered that the swelling was due to a mucocele of the frontal sinus.

March 7th, 1908. Operation by Mr. Steward. Adrenalin and cocaine were applied to the nasal mucous membrane, and patient anæsthetised. Owing to the ischæmia produced by the adrenalin a better view of the middle meatus was now obtained, and it was seen that the outer wall of the anterior part of the meatus bulged inwards. A blunt instrument was pushed through the bulging area and a cavity opened which was found to be a distended anterior ethmoidal cell, in direct communication with the distended frontal sinus. About one ounce of mucoid fluid and muco-pus escaped. The anterior end of the middle turbinate bone was now removed and the opening into the meatus enlarged with cutting forceps, so that it was made quite three-quarters of an inch in diameter. A large rubber drainage tube was now introduced.

March 24th, 1908. Patient has done well; the proptosis has almost disappeared and the discharge, which after the operation was at first profuse, has now almost ceased. Patient looks, and says she feels, well and has no pain. The cavity has been daily irrigated with hydrogen peroxide and looks quite healthy. The opening into the nose is smaller, but is still quite patent.

The patient shortly afterwards was admitted to an asylum, and we have since lost sight of her. But within a year a precisely similar case, with the same rather soft swelling at the upper and inner angle of the orbit, came to the hospital. This also Mr. Steward operated on in the same way; there was a similar protrusion in the middle meatus, and it was drained through the nose with equal success. We have at the present time on the books for admission the name of another patient with an identical condition. So in less than two years here are three cases of the kind. In no case has there been any interference with vision, optic neuritis, or atrophy.

Pressure on the optic nerves.—If you get a dilatation of the sphenoidal cells or posterior ethmoidal cells, you will see that you will get not so much a proptosis of the eye as some pressure on the optic nerve, for you have seen that the optic nerve is only separated from those cells by a very thin bony partition. The earliest case which called my attention to this condition was one I saw in 1905, in which I had reason to suspect that some dilatation of this sort had caused temporary blindness in a patient whom I had admitted for a different condition altogether. She was admitted in the ordinary way into the Eye wards for a conical cornea, which, therefore, required an operation to make its surface more spherical. She had comparatively good vision in the right eye, the one on which I was proposing to operate. She could not be taken in at the time, and when, a few days afterwards, I saw her in the ward just previous to the operation, she could only just distinguish between light and darkness in the right eye. I could not see anything abnormal in the fundus oculi itself, and I thought probably we had made some mistake at Out-patients, and it was useless to do any operation on an irregular cornea for a patient who could only distinguish between light and darkness. I therefore discharged her, and said there was nothing to be done. But a fortnight after her discharge she came to Out-patients and said that one day she was bending down and suddenly felt severe pain in her head. She felt something give way, and noticed blood and matter exuding from the nose and mouth. The pain in her head was then relieved, and by the time she came to Out-patients she had no further pain, and her vision had got back to the state in which it was when I first saw her. I think there is no doubt that that case was one due to compression of the optic nerve by the dilatation of one of the accessory sinuses of the nose. Such cases have been reported in greater numbers since attention has been drawn to the subject. But cases of simple compression of the optic nerve are, I think, comparatively rare in comparison with the other conditions which may occur as the result of the inflammation of the posterior ethmoidal and sphenoidal cells.

Optic neuritis.—Inflammation of these sinuses may be associated with some periostitis, and this periostitis may spread to the wall of the optic foramen, and so to the optic nerve itself. And you may therefore get either unilateral or bilateral inflammation of the optic nerve, which starts high up in the optic nerve, causing at first failure of vision without visible ocular signs, and spreading slowly down the optic nerve to appear later on in the eye, as a definite inflammation of the optic disc itself. And in this connection I want to speak about a condition which has

long presented some obscure points, viz., that known as *retrobulbar neuritis*. Oculists have long been familiar with cases, usually young men or women who, with apparently no general nervous disease or intra-ocular affection, are afflicted with sudden blindness in one eye, which is usually ascribed to chill, excessive tea-drinking, constipation, or other unsatisfactory cause. The patient may lose his vision in 12 or 24 hours, and may remain blind for about two or three days; then the vision will slowly come back, until at about the end of a week or a fortnight the greater part has returned. Usually there is some pain on the affected side of the head, with neuralgia, and some tenderness on pressure over the eyeball. The permanent defect of sight, if any, is generally a lesion of the axial fibres of the optic nerve, giving rise to a loss of the central part of the field of vision. This type of case has been called "retrobulbar neuritis," because when the attack first comes on nothing is seen in the eye; later, however, neuritis is seen to appear slowly at the disc when the vision is improving. As one eye only is affected, the lesion is evidently an inflammatory condition of the optic nerve behind the globe, and between it and the optic chiasm. Now it is possible, although the pathology of this condition has always been obscure, that some of these cases of retrobulbar neuritis may be due to direct implication of the optic nerve in lesions of the sphenoidal and ethmoidal sinuses, either by direct pressure or periostitis in the optic foramen. And Professor Onodi, in his book, cites cases of this sort, both bilateral and unilateral. He quotes the case of a girl who had well-marked optic neuritis and partial atrophy of both optic nerves, associated with an empyema of the sphenoidal sinus. On the sphenoidal sinus being opened and drained, the condition subsided, and the patient's vision returned in both eyes. He quotes also the case of an unilateral optic neuritis, in which an empyema of the sphenoidal sinus on that side was found, draining of which caused a relief of the symptoms, and a return of the patient's vision. And at the Ophthalmological Congress at Heidelberg, in 1906, he collected all the cases he found published of inflammation of the nasal passages on one side, with neuritis or atrophy of the opposite optic nerve. And in a very good discussion at that Congress he first brought forward the anatomical considerations I have mentioned previously. Remember, therefore, that in addition to proptosis of the eye there may be bilateral optic neuritis, proceeding, if the condition is not relieved, to atrophy and permanent loss of sight. Then there may be *periostitis and cellulitis of the orbit*. The symptoms of the latter condition are familiar to you all—great swelling of the orbital tissues, engorgement of the veins, fixity and proptosis of the eye; these make a picture which you are unlikely to mistake for anything else, except one condition which I shall shortly mention. There may also be inflammation of the motor nerves which enter the orbit at its apex, followed by convergent or divergent strabismus; and in some cases thrombosis of the central retinal veins, or embolism of the central retinal arteries. Also, from the spread of the inflammation from the ethmoidal cells forward, there may be periostitis and necrosis of the lacrymal bone, giving rise to acute suppuration in the lacrymal sac.

Thrombosis of the cavernous sinus.—But the most dangerous condition which may arise in connection with inflammation of these nasal sinuses is that known as thrombosis of the cavernous sinus. The close proximity of the cavernous sinus to the sphenoidal sinus and the posterior ethmoidal cells makes it liable to attacks of inflammation in suppuration of these cavities, and you should, therefore, be quite familiar with the diagnosis of thrombosis of the cavernous sinus, and the differential diagnosis between it and cellulitis of the orbit. Thrombosis of the cavernous sinus is not very common, but the last case which came under my notice was due to fronto-ethmoidal disease, a case under the care of Mr. Steward in the Eye wards. The usual symptoms are a sudden swelling and œdema of the lids and conjunctiva. The eyeball is protruded and absolutely fixed, in contrast to the displacement with some mobility, such as you get in proptosis due to simple dilatation of the ethmoidal or sphenoidal cells. There is a great distension of the ophthalmic and frontal veins. Also, as the eye is exposed and the patient cannot close the lids, there may be ulceration of the cornea. A characteristic symptom of thrombosis of the cavernous sinus is that in these cases there is always a doughy œdema over the mastoid region, the reason being that the cavernous sinus communicates with an emissary vein which opens just over the petrous bone, and with some of the petrosal sinuses. And the septic process in the cavernous sinus spreads along these emissary veins and becomes evident externally over the mastoid region. The condition can be diagnosed from orbital cellulitis with absolute certainty by remembering this œdema over the mastoid, and the additional fact that thrombosis

of the cavernous sinus usually spreads to the opposite side, because the cavernous sinuses on both sides communicate by means of the two straight sinuses; on the other hand, orbital cellulitis on both sides is very rare. These cases, without exception, lead to septic meningitis and death. The condition is comparatively uncommon in these days, because purulent diseases of the frontal and ethmoidal sinuses are treated earlier and more radically than formerly.

Without going too much into detail, then, these are the main affections which may occur in the eye as the result of accessory sinus inflammation of the nose. But I ask you not to be too enthusiastic in diagnosing sinus disease in every case of monocular blindness which you may see. Some authors in their enthusiasm seem to be attributing to dilatation of the accessory sinuses of the nose such conditions as disseminated choroiditis and glaucoma, with very little apparent justification. On the other hand, since Mr. Steward and I have been interested in this condition we have carefully examined every patient who has come into the wards or Out-patients suffering from any optic neuritis or optic atrophy of obscure origin. And I may tell you that we have in the last three years met no case which we could definitely say was due to any existent nasal disease, with the exception of these cases of proptosis; no case of optic neuritis or optic atrophy showed anything abnormal in the nose. Yet some people are opening up and washing out the nasal sinuses in all such cases of neuritis of obscure origin and publishing them as successful because the vision has ultimately returned. But cases of unilateral optic neuritis do get well, and have for many years, without the sphenoidal and ethmoidal sinuses being irrigated. You have no right to consider that any case of optic neuritis is due to inflammation of these cells unless there is nasal evidence of disease; and that, of course, is a matter not for me, but for the nasal specialist.

Papers, etc., Received.

Record of Sports. 7th edition. Published by the Royal Insurance Company, Ltd.

This is a useful little book of reference, containing the records, up to the end of 1909, in almost every branch of English sport. The sections on cricket and golf are particularly full of interesting records and information. In this issue a new section on angling, with records of fly and bait casting and record fish, is introduced.

We understand that the Royal Insurance Company will be happy to supply a copy of the booklet, so far as their stock will permit, to any of our readers who care to apply to their South London branch at 56, Borough High Street.

Pass List.

Royal College of Surgeons of England.

LICENCE IN DENTAL SURGERY.

FIRST PROFESSIONAL EXAMINATION, MAY, 1910.

*H. L. Bailey.	†W. J. O'Kane.
D. H. Barr.	R. Orozco-Casorla.
S. W. Bevis.	W. L. Partridge.
†A. J. Chapman.	†P. J. Peatfield.
†H. C. Corke.	†C. J. Phillips.
J. E. Davies.	H. N. Purdom.
*C. M. Desai.	†J. H. Ross.
R. L. Donn.	I. G. Samuels.
*H. G. Elliott.	C. H. Stainer.
E. L. Fraser.	†R. R. Steele.
V. Fitz-H. H. Golledge.	R. D. Tanner.
†C. H. Housden.	F. J. Tipper.
*E. S. Huckett.	R. McK. Veale.
*W. S. Lakeman.	F. R. Wallis.
C. H. Medlock.	†S. J. F. Webb.
C. D. Neale.	E. R. Williams.
†R. Neft.	*F. Wisher.

* Mechanical Dentistry only.
† Dental Metallurgy only.

University of Cambridge, May, 1910.

DEGREE OF M.D. CONFERRED.

H. C. Cameron (John). | A. H. Miller (Trinity).

D.P.H. (Both parts).

H. P. W. Barrow, Major R.A.M.C.

Royal College of Physicians of London.

ELECTED FELLOWS OF THE COLLEGE.

Francis Edward Fremantle, M.B. Oxon.
David Forsyth, M.D. Lond.
Arthur Frederick Hertz, M.D. Oxon.

Change of Address.

Hugh T. Campkin, L.D.S. Eng., from 14, Harley Street, W., to 71, Harley Street, W.

H. Fulham-Turner, M.R.C.S., L.R.C.P. Lond., from "Torwood," Colney Hatch Lane, Muswell Hill, N., to "Bosworth," Colney Hatch Lane, Muswell Hill, N.

Dr. E. Baxter Forman, J.P., from 11, Bramham Gardens, South Kensington, S.W., to Newmount, Chalfont St. Giles, Bucks.

Herbert P. Hooper, L.D.S. Eng., from 28, New North Road, Huddersfield, to the Mansion House, Peterborough.

Captain G. E. Malcomson, M.D. Lond., I.M.S., from c/o Messrs. Grindlay, Groom & Co., Bombay, to c/o Messrs. Grindlay & Co., 54, Parliament Street, S.W.

J. G. Morrell, L.D.S. Eng., from 7, High Street, Stockton-on-Tees, to 9, Bishopton Lane, Stockton-on-Tees.

W. Reginald Ransford, L.D.S. Eng., from Maymyo, Burma, to Soolay Pagoda Road, Rangoon, Burma.

Some Forms of not very obvious Pyuria.

A Paper read before the Lambeth Division of the British Medical Association

BY HERBERT FRENCH, M.D., F.R.C.P.

IT is only with a small portion of the subject of pyuria that we shall have time to deal to day, and I do not propose to touch at all upon such conditions as produce an abundant deposit of pus when a sample of urine is allowed to stand in a specimen glass. I shall, therefore, exclude all conditions of acute and chronic cystitis, whether due to calculus, tuberculous inflammation or ulceration, or growth, or septic infection of the bladder. I do not propose to deal with the pyuria that may result from the retention of urine that results from stricture, or enlarged postate, or from such nervous diseases as transverse myelitis, or locomotor ataxia; neither do I intend to deal with any of the renal conditions whose nature is more or less obvious and in which pyuria is a marked symptom—for instance, pyonephritis or advanced calculus, tuberculous or malignant disease of the kidney. The group of conditions to which I should like to allude chiefly is one in which there is no ammoniacal decomposition of the urine; the reaction is usually acid, the smell is not decidedly abnormal, and although the specimen may be a little turbid, there is no such quantity of pus as can be detected by the liquor potassæ test, so that unless a careful microscopical examination of the centrifugalised deposit of the urine is made, the diagnosis of pyuria may be altogether missed.

The symptoms in these cases may not even suggest at first sight that the trouble is in the kidney, or in any other part of the urinary tract at all, and the patients may be mistaken for sufferers from appendicitis, acute gastritis, or gastric ulcer, intestinal obstruction, lobar-pneumonia, general peritonitis, or even cerebral tumour. The reason why such various diseases may be erroneously diagnosed instead of the pyuria of which we are about to speak is that, as has already been mentioned, to a casual examination the urine appears to be normal, and also that the symptoms are very apt to be either severe pain in the abdomen, particularly in the right side, in the flank, or in the right iliac fossa, or even general abdominal pain, or else to be of a more or less uræmic type, with a preponderance of nausea, anorexia, and severe headache on the one hand, and persistent vomiting upon the other.

It is clearly impossible for me to describe to you all the different types of symptoms that may arise, but I may remind you that one form of the disease is being recognised with increasing frequency as the pyuria of pyelitis of pregnancy. If you will allow me, I will read you the notes of a mild and of a severe case respectively of this malady, of which I am able to show you these two temperature charts; in each case you will notice that there was considerable pyrexia, lasting in the severe case for nearly ten weeks and in the mild case for about one week. I have recorded these cases elsewhere, but if I may I will repeat briefly the notes of them.

The following is the severe case: The patient was 24 years of age, and had been married two years. She had had no living child, but nearly a year before her admission she had had a miscarriage at the fourth month, followed by rapid and successful recovery. She was now 5½ months pregnant, and she had been perfectly well until four months before her admission, when, almost suddenly and without apparent cause, she experienced severe pain in the right side of the abdomen, starting in the flank and extending to the region of the right iliac fossa. This pain had spread round to the loin, and it also became so severe that the patient referred it more or less to the whole of the abdomen, though always more at the right iliac fossa than elsewhere. She had always been a constipated subject, her bowels, as a rule, never being moved more than twice a week, and during the fortnight previous to her admission she had required repeated enemata. There had also been vomiting, and on admission the pulse rate was 124; respiration, 26; and temperature, 102°F.; the chart that is being passed round shows how very serious her illness turned out to be. The uterus extended up to the umbilicus, and owing to the pregnancy palpation of the rest of the abdomen was difficult. Tenderness and pain were more marked in the right iliac fossa than elsewhere, and at first it seemed obvious that the patient was suffering from appendicitis; even when it was found that there was some tenderness extending into the right flank appendicitis seemed to be by no means excluded, because the appendix might well have been retrocæcal, the inflammation tracking up into the kidney region behind the colon. No lump was to be felt, and the right loin was not filled out. A careful examination of the urine showed that the latter was acid, and of a pale yellow colour. There was a light flocculent deposit which microscopically contained many pus corpuscles; no blood was present, but there was a fair amount of albumin.

In addition to the pus cells there were a few renal tube casts and renal epithelial cells, but no crystals and no tubercle bacilli. The conclusion come to was that the patient was suffering not from appendicitis, but from pyuria of pregnancy. This was confirmed both bacteriologically and by operation. A catheter specimen of urine gave a pure culture of the bacillus coli communis on three different occasions. It may be mentioned that there was no disease of the bladder at all, for the cystoscope was used, and the vesical mucosa was perfectly healthy. Notwithstanding treatment by rest in bed, urotropine, and by bland diet, the patient seemed to be getting worse instead of better. Vomiting became incessant, and the whole condition seemed to be one of such extreme gravity that it was finally decided to perform an operation. The right kidney was examined by Mr. Steward, and found to be studded all over with small abscesses; at first it was thought that the organ should

be excised, but the patient was so ill that her wound was merely drained, and she was returned to bed. Notwithstanding the fact that the kidney was so exceedingly diseased, a complete recovery ultimately resulted, and it is possible that this was to some extent due to the treatment of the case by a vaccine prepared by Dr. Eyre from the bacillus coli communis.

The next case is a mild one of the same disease. The patient was 28 years of age; she had had two children aged 5 and 2 years respectively, and there had been no miscarriage. She was pregnant for the third time when at the beginning of the fifth month she was suddenly seized with severe pain round the waist. The suddenness of the onset of the symptoms may be gathered from the fact that she was preparing her husband's mid-day dinner when the pain seized her acutely in the flanks, particularly in the right side, and she was unable to go on with her cooking; she also vomited, and although she was put to bed and kept there, she continued in great pain and was persistently sick, notwithstanding the fact that her diet was milk and soda only; in addition to the vomiting there had been severe headache and abundant perspirations. After she had been in bed a fortnight she showed so little improvement that she was transferred to the hospital. When examined, the abdomen was supple, and it moved well with respiration, but there was acute tenderness and pain to the right of the umbilicus and also in the right iliac fossa; upon further examination it was found that there was a very tender spot just below the right 12th rib, and the urine was found to contain a trace of albumin. It did not deposit any obvious pus, but upon microscopical examination large numbers of pus corpuscles were found in the centrifugalised deposit, and there were also numbers of bacteria even in the fresh specimen. Cultures made from it gave a pure growth of bacillus coli communis. Absolute rest in bed and the administration of urotropine led to a rapid improvement, as shown by the temperature chart, and in three weeks' time the patient went out at her own request, though there were still pus corpuscles in the centrifugalised deposit of the urine. As a matter of fact, she returned to her household duties too soon, for within a fortnight she was again severely ill, but under similar treatment a second recovery resulted, and owing to the greater care she then took of herself she went the full term and the baby was born alive and healthy, and she herself has remained quite well since.

I have necessarily made the account of these two cases very brief, but they will serve the purpose, I think, of showing that there is a condition in pregnancy known as pyelitis, in which there is a small quantity of pus in the urine, the condition being due apparently to infection of the urinary passages by the bacillus coli communis being excreted by the kidney from the blood stream. There is no infection of the bladder in these cases, so that the condition is not one of ascending nephritis or surgical kidney. The nature of the mischief might easily be overlooked were it not for microscopical examination of the urine, and one of the things which helps one with the diagnosis, as a rule, is the presence in the urine of albumin, in small quantities or in large. It emphasizes the need once more for the examination of the centrifugalised deposit in every case in which the urine contains albumin.

The next point that I wish to bring out is this: that not only has the condition of pyuria of pregnancy only been recognised comparatively recently, that is to say, during the last ten years or so, but also that those who have paid most attention to the subject have spoken of it as though it were a condition of which pregnancy was an essential part. I want to bring out as clearly as I can the fact that although the occurrence of pyuria is apt to be very much aggravated by pregnancy, it is not caused by pregnancy, and that it may therefore occur in non-pregnant persons. I should like to give illustrative cases of a precisely similar affection in men as well as in women, in boys and girls as well as in grown-up persons, but the exigencies of time prevent me from doing so in any detail. I should like, however, to say that the condition is almost common, and that during the last few weeks one has had good opportunity of seeing several striking examples of it. Thus there was the case of a man of 55 who began to ail and to lose his appetite, who was sick after his food, and complained of indeterminate and vague pains in his abdomen which sometimes seemed to be more marked on the right side, sometimes more on the left, now here, now there; the bowels were very constipated, and vomiting became serious, so that there was considerable suspicion that the patient was suffering from chronic intestinal obstruction, due perhaps to carcinoma of the colon. Notwithstanding the patient's wasting, the abdomen seemed unduly full. On examining the urine it looked normal at first sight, it was acid and of specific gravity of 1015, there was no obvious appearance of pus, and the specimen did not seem abnormal, except that it looked a little less clear than normal; it smelt natural. On testing in the ordinary way, however, it was found to contain a small amount of albumin, and although this might well have been due to senile changes in the kidney or something of that kind, a microscopical examination was made and the centrifugalised deposit was found to contain abundant pus corpuscles and micro-organisms of the bacillus coli communis type. Notwithstanding treatment, the patient got worse and worse, his main trouble being the vomiting, and this caused him to be unable to take enough food to keep him alive, and he died practically of uræmic starvation. There are no convulsions in these cases, and it is quite clear how the diagnosis might have remained at chronic intestinal obstruction if the possibility of pyelitis had not been kept in mind.

Another case was a woman aged 35, who was not pregnant, nor had she been. She gave a history of having had vague abdominal pains for some time, and of having been out of sorts, and constipated, with deficiency of appetite. She then developed, almost suddenly, acute pains, localised to the right iliac fossa, and these were accompanied by local rigidity, by vomiting, by pyrexia,

similar to that which I have already shown you on some of the charts I have passed round, and by a rising pulse rate. It seemed that the condition was one of acute appendicitis, and owing to the increasing pulse rate and the persistent vomiting it seemed correct practice to operate. When the abdomen had been opened, the vermiform appendix was found to be perfectly healthy, and there was no general peritonitis; the diagnosis then seemed to be intestinal obstruction, possibly by a band, and, therefore, a most careful examination of every part of the abdomen was made, but nothing whatever abnormal could be found. Whether due to the inevitable traction upon the mesentery, and consquent interference with the solar plexus, or whether due to the toxæmia which had produced the symptoms previous to the operation, acute dilatation of the stomach ensued, with vomiting of quarts and quarts of black fluid, and death occurred within a few hours of the operation. At the post-mortem examination acute pyelitis and acute ureteritis were the only lesions found, and the reason why the symptoms had been so definitely localised to the right iliac fossa was that there was very acute inflammation of the last two inches of the right ureter, and this had produced pain and other symptoms precisely similar to those of acute appendicitis. It seems clear that in this case, had one not been so impressed with the urgent necessity for operation, one would have made a more detailed examination of the urine first, and possibly, had one recognised the importance of a small amount of albumin and of numerous pus corpuscles upon microscopical examination, one might have refrained from laparotomy and cured the patient by means of urotropine or some similar drug. I have notes of various other cases, but I need not enter into them now. I will add, however, one instance of a precisely similar affection in a child.

Bacillus Coli Communis Pyelitis in a Child.

The patient was a little girl, aged 6, who was admitted to the hospital on 24th March, 1909, for pain in the right side of her abdomen and for vomiting. In the previous December she had first begun to complain of pain in the right iliac fossa, and simultaneously she used to vomit material of a green colour, obviously bile stained. Along with these symptoms were headache and constipation. There had been altogether three severe attacks of this nature, the last beginning ten days before her admission and persisting since. She was at the same time flushed and thirsty, she had little appetite, and was losing weight rapidly. There had been slight pyrexia at first, but the temperature rapidly fell to normal after she had been a short time in the ward. The pulse rate at first varied from 168 to 128, but later it became slower, though it was not normal even at the end of ten weeks. At first the diagnosis seemed to lie between recurrent appendicitis and tabes mesenterica. The urine did not look very abnormal to the naked eye; it was not quite clear, but it did not smell abnormal. It was acid in reaction. Microscopical examination showed many pus cells and stringy threads of mucus, but no crystals, nor any tube casts. Upon bacteriological examination of a catheter specimen, a pure growth of bacillus coli communis was obtained. Treatment was by means of urotropine in 5-grain doses, and also by means of increasing doses of bacillus coli communis vaccine.

The patient was discharged completely cured and free from pyuria, but it took three months to effect this result.

In connection with all these patients, I would beg of you to remember that I am bringing them before you as instances of pyuria, and that therefore the diagnosis may seem to you to be obvious enough. But if one can put oneself in the position of a medical man who is confronted with a case for the first time, without the knowledge of the microscopical characters of the urine, I feel sure that many cases of the kind would really be regarded as something entirely different to pyuria. The disease is relatively common. It seldom gives any symptoms which mark the fact of there being an infection of the urinary system. I think, however, I may say that it seldom occurs without there being at least a trace of albumin in the urine, and this may be very helpful, and the first clue to the diagnosis. Another fact about these cases seems to be that although both kidneys may be affected, for some reason or another which I will not discuss here, the right urinary tract seems to be much more frequently affected than the left. Another salient feature of almost all these cases is that the infection of the urine is by the bacillus coli communis, and it has been suggested that this enters the urinary tracts from the blood-stream by being excreted by the kidneys in people who have some undue absorption of these micro-organisms as the result of undue constipation on the one hand, or inflammation or other affection of the colon on the other. The bearing of this upon treatment is clear, for besides treating the urinary tract it is essential to pay attention to the bowels. It is not necessary to purge the patients, but the well-known steps for the relief of constipation should be adopted, always remembering that the best treatment for constipation is *encouragement of the regular habit*, and not *compulsion of intestinal action* by means of any drastic purge.

Many observers scoff at the idea that any antiseptics that can be given by the mouth will be of use in disinfecting the bowel; the use, for instance, of such drugs as naphthol, salol, glycerine of carbolic acid, sodium, sulphocarbolate, essential oil of cinnamon, and creosote. I would ask you to remember this, however, that whereas a considerable percentage strength of an antiseptic may be necessary to actually destroy the life of micro-organisms, a very much weaker solution will inhibit the same organisms from multiplying so fast as they otherwise would. I mean that whereas it may take a solution of 1 part in 20 of carbolic acid to kill a given growth of micro-organisms, I feel sure that if a bacteriologist had a very pet culture of some rare organism that he wanted to grow and multiply, he would be very sorry indeed if anybody were to put even one drop of a 1 in 5,000 solution of carbolic acid into the culture media. Exceedingly small quantities of carbolic acid will inhibit bacterial

growth, and if this can be accomplished in the intestines it is clear that each evacuation may get rid of so many more bacteria than have grown in the last 24 hours, that even small doses of antiseptics may indirectly lead to disinfection of the intestines, that is to say, to a diminution of the number of microbes in the bowel; it is therefore worth while to prescribe any of the above remedies in addition to taking steps to cure the constipation. Besides this, especially in pyrexial cases, it is most important to keep the patients in bed and to continue to keep them in bed even some time after they seem to have got well, for if they get up too soon there is almost certain to be a recurrence of the pyelitis. The diet in the acute stages should be of the blandest, milk being the staple food as long as there is pyrexia; the great tendency to nausea and vomiting indicates the difficulty the stomach is likely to have in digesting anything like ordinary diet. It is noteworthy that the bacillus coli communis is the common organism in these cases, and it seems that much benefit may sometimes be obtained by means of bacillus coli vaccines. Some cases seem to have derived benefit from vaccine treatment, others not; but whether vaccine treatment be employed or not, it is certain that it would be unwise to omit to give one of the urinary disinfectant drugs, of which I would mention in particular urotropine. This should be given in quite large doses, that is to say, as much as ten grains four or even five times a day, provided that the patient is drinking enough fluid to make the urine not too concentrated. Urotropine is excreted by the kidneys as formalin, and it is only dangerous, I think, when the urine, and consequently the formalin in it, is too concentrated. In a few cases this drug produces hæmaturia; when it does so it is probably wiser to desist from giving any more of it, and to replace it by some other drug such as helmitol; but as a matter of fact one does not generally find that the hæmaturia produced by urotropine is followed by any ill-effects, and it is a first-class remedy in the type of pyuria cases of which we have been speaking.

Papers by Guy's Men.

R. W. Allen, M.D., B.S. Lond.: The Bacillus Influenzæ and Symbiosis.—*The Lancet*, 7th May, 1910.

A. P. Beddard, M.A., M.D. Camb., F.R.C.P. Lond.; Secondary Constipation.—*The Practitioner*, May, 1910.

A. Z. C. Cressy, M.R.C.S. Eng., L.S.A.: The Knife and its Point (Illustrated).—*British Medical Journal*, 7th May, 1910.

Arthur F. Hertz, M.A., M.D. Oxon., M.R.C.P. Lond.: The Investigation of Constipation by the X-rays (Illustrated).—*The Practitioner*, May, 1910.

W. Arbuthnot Lane, M.S. Lond., F.R.C.S. Eng.: The Operative Treatment of Chronic Constipation Illustrated).—*The Practitioner*, May, 1910.

Arthur Ormond, F.R.C.S. Eng.: Sympathetic Ophthalmia.—*The Clinical Journal*, May 11th, 1910.

Nursing News.

GUY'S HOSPITAL NURSES' LEAGUE.

The Second Annual Dinner and the Tenth Annual General Meeting of the Guy's Hospital Past and Present Nurses' League were held on Friday, April 29th, in the Nurses' Home.

Dinner was served in the Nurses' dining-hall, the tables looking very pretty with the bright cutlery and glass, and the floral decorations of spring flowers. The Home Sisters are to be congratulated on the excellent way in which the arrangements were carried out.

Punctually at seven o'clock the Matron took her seat at the centre table. There were between seventy and eighty guests, among them being:—Miss Bolton, Matron, Cottage Hospital, Enfield; Miss M. Bryan, Matron, General Hospital, Northampton; Miss Hall, Matron, Seamen's Hospital, Greenwich; Miss Hoadley, Matron, London Homœopathic Hospital; Miss Victoria Jones, late Matron, Guy's Hospital; Miss O'Neill, Matron, Military Families' Hospital, Portsmouth; Miss Oxford; Miss Oyler, Matron, Gloucester Infirmary; Miss Rogers, Matron, Royal Infirmary, Leicester; Miss Sleap, Matron, Queen Victoria Hospital, East Grinstead; Miss E. Stevens, Matron, Cottage Hospital, Chippenham; Miss E. Studdert, Matron, Hertford County Hospital; Miss Vance, Matron, Cottage Hospital, Ealing; Miss E. Fraser and Miss E. Shackleton, late Matron and Assistant Matron, Children's Hospital, Winnipeg, Canada.

During the dinner a telegram of greeting from the members assembled was sent to Miss Swift, who had recently returned to England.

After dinner tea and coffee were served, and a great many members who were unable to be present at the dinner joined the party, and for a time much talk and laughter prevailed.

Soon after eight o'clock everyone adjourned to the large Nurses' recreation sitting-room where the business of the evening was transacted. The Matron, after a few words of welcome to the members, asked Miss Rogers to take the chair.

After the minutes of the last Annual General Meeting had been read, confirmed and signed, the following resolution was proposed by Miss Victoria Jones, seconded by Miss M. E. Powell, and carried unanimously:—"That the Members of the Guy's Hospital Past and Present Nurses' League desire to place on record their warm appreciation of the valuable advice and help they have invariably received from Miss Swift as Hon. Secretary since 1901. They feel it is chiefly due to her energy that the League was founded, and has attained its present successful position."

The Matron, as Hon. Secretary, then gave the report of the year's work. Between 80 and 90 new members had joined the League. 146 Sisters and Nurses had spent week-ends, days and nights off at the cottage, and 700 short visits for tea, &c., had been paid. 3,570 volumes

had been taken out of the Nurses' Library, and between 70 and 80 new books had been added.

The Musical Society, with which is incorporated the Nurses' Choral Society and Orchestra, gave a very successful concert in December, and had also given a selection of sacred music in the chapel on Good Friday.

The Swimming Club had held a tournament during the season, but the Tennis, Cycling and Hockey Clubs had been prevented by bad weather from doing much work.

The Debating Society had held debates, at one of which Mrs. Percy Boulnois had given a very interesting address.

The Photographic Society, now holding its Sixth Annual Exhibition, had fewer exhibits than the previous year, but the standard of the work on the screens still remained high.

The course of Post-graduate Lectures now being given were well attended, and much appreciated, not only by Guy's Nurses, but by Nurses from other hospitals. In the absence of Mrs. Fagge, the Hon. Treasurer, the Matron stated that the finances were in a very satisfactory condition, and that it was hoped that the League would eventually be able to pay the debt off the cottage. The debt at first stood at £4,059; now it was £2,370, a sum of £300 having been paid off during the past year.

Miss Rogers next addressed the meeting, and said what a great honour she considered it when she was asked to take the chair at the meeting that evening. They might wonder why she, a country cousin, had been invited to occupy the chair, but she had once been Sister Clinical, though some of those present were probably in their cradles at the time. It was due in a great measure to the Guy's Nurses' League that the Leicester Nurses' League was started, and another link was that the Leicester Infirmary owed to Guy's its first trained matron, Miss Burt, who, after putting the nursing on a better basis at Leicester, returned to Guy's as Matron. Leagues would, Miss Rogers said, play a great part in organisation, and they had a good professional as well as social side. They were of great value in helping their members to take an interest in what was going on round about them, and also to look out into the world and see what others were doing. She then quoted Lady Helen Munro Furgusson's address to the International Congress of Nurses on "The Nurse as a Citizen." "Even now there are hundreds of nurses who take no interest in the larger trusts of their profession, and who feel no responsibility for its corporate welfare. Such nurses are not leading the full citizen life; they are neglecting the way by which their individual and collective influence may be enhanced. You have too many vested interests, too many superstitions, too many prejudices to overcome, to tolerate any drones amongst yourselves." In conclusion, Miss Rogers said that as one heard of fresh fields for nurses on all sides, it was difficult not to feel a little jealous of the nurses of to-morrow, who would see the building, whose foundations had been laid with so much care, rise up. She wished the Matron, Sisters and Nurses of Guy's a happy and honourable career.

The result of the ballot for the election of Members of Council was next announced as follows:—

Nurses' Library.—Sister Cornelius, Nurse Cox.
Nurses' Orchestra.—Sister Surgery, Nurse Rees.
Nurses' Hockey Club.—Sister Florence, Nurse Dowley.
Nurses' Tennis Club.—Sister Theresa, Nurse Hodgkinson.
Nurses' Choral Society.—Sister Ruth, Nurse Hinds.
Nurses' Photographic Society.—Sister Jentie, Nurse Allen.
Nurses' Swimming Club.—Sister Ellen, Nurse Schlagentweit.
Nurses' Cycling Club.—Sister Addison, Nurse Marriott.
Nurses' Debating Society.—Sister Lydia, Nurse Macmanus.

The Matron then proposed the confirmation of the election of the Associate Members of Council—The Countess of Bective, Lady Fripp, Lady Perry, Mrs. Hankey, Mrs. Lane, Mrs. Trevelyan Martin, Mrs. Symonds, Mrs. Taylor, and Mrs. Hale White. The proposition was seconded by Sister Lydia, and carried unanimously. A hearty vote of thanks to Mrs. Cosmo Bonsor, the President, and to these Associate Members of Council was also carried unanimously.

A hearty vote of thanks was accorded to Mrs. Fagge, the Hon. Treasurer, on the proposal of Miss Oxford, seconded by the Matron, and to the retiring Members of Council on the proposition of Miss Vance, seconded by Miss Lemon.

The business then terminated. A very hearty vote of thanks, proposed by Miss Bryan, seconded by Miss Oyler, to Miss Rogers, for making the special journey to preside at the meeting, was carried amid great applause. Miss Rogers, in reply, said how very much pleasure it had given her to be present that evening, and that she would be only too delighted (if the Nurses' League would charter a special train) to see all the members at Leicester.

After the meeting an exhibition of Lantern Slides was given, portraits, and those depicting scenes in the Hospital, receiving much applause. There were also 100 slides, "The Cape Beautiful," lent by the Royal Photographic Society of Great Britain, which were greatly appreciated.

Shortly after ten the members began to disperse, and and on all sides it was heard how greatly the evening had been enjoyed by those present.

GUY'S HOSPITAL NURSES' PHOTOGRAPHIC EXHIBITION.

The Sixth Annual Exhibition of the Guy's Hospital Nurses' Photographic Exhibition was opened in the Nurses' Home on Friday, April 29th. There were about 200 entries, divided into four classes, there being a special class for those members who did not do all the work themselves. The awards were again placed at the disposal of the judge by the Countess of Bective, Mrs. Cosmo Bonsor, and Mrs. Trevelyan Martin. The photo-

graphs were judged by Mr. F. T. Hollyer, and his awards were as follows.

Class A.—

1st Prize	"The Road to the Farm."	Miss Smith.
2nd "	"Scotch Firs."	Nurse Keays.
3rd "	"Concarnean Harbour."	Miss Grahame.

Class B.—

1st Prize	"The Procession."	Miss Grahame.
2nd "	"Bunch."	Miss Smith.
3rd "	"Taken Unawares Again."	Nurse P. Wallis.

Class C.—

1st Prize	"The Colonnade Steps."	Sister Jentie.

Class D.—

1st Prize	"Valentia Island."	Sister Jentie.
2nd "	"Henley Crews."	Nurse P. Wallis.
3rd "	"Anstey's Cove, Torquay."	Sister Millicent.
Hon. Mention	"On the Stepping Stones."	Nurse P. Wallis.
" "	"The Sardine Boats."	Miss Grahame.

Special prize for best exhibit—

"The Road to the Farm." Miss Smith.

Special prize for best exhibit by a Nurse at present working in the hospital—

"Scotch Firs." Nurse Keays.

A special feature of the Exhibition was the large number of Indian photographs which had been sent in by Miss Tippitts and Miss Webb, Lahore; Miss Wilkinson, Delhi; Lieut. and Mrs. Barker, Major and Mrs. Hugo, Capt. Watts, and Capt. Beadnell; the photographs by the last were kindly lent by the Editor of the GAZETTE.

The photographs were arranged on screens covered with Hessian, and draped with green art muslin, which made an effective setting to the exhibits. The number of photographs sent in was not so large as last year, but the judge said the standard of the work was well maintained, and he gave several useful hints for future work.

The Annual Report.

THE Treasurer's Report for 1909, which has lately been issued, is a record of successful accomplishment during the past year, on the one hand, and, on the other, an appeal for the necessary funds with which to carry out other necessary changes in the coming year:—

The past year has been happily distinguished by several important features. The wards never rendered greater service to the suffering poor, the 8,933 in-patients accommodated being substantially in excess of the number for any previous year in the existence of the Charity. The New Out-Patient Department, which supplies what for long had been a great need, was completed, occupied, and its cost discharged, and a sufficient income from all sources received to meet the year's expenditure. These are matters for gladness and gratitude, and of encouragement for the future. Much, as will be seen hereafter, remains to be done, and time creates fresh needs, but on a survey of what has been accomplished since 1895, and recorded in previous Reports, the friends of the Hospital and the public generally will doubtless join with accord in the formal expression, made by the Governors in May last, of their great satisfaction at the change which had taken place in the position of the Foundation of Thomas Guy.

His Royal Highness, the President, and the Princess of Wales paid a private visit to the Hospital on the 13th February, 1909, and once again evinced their warm interest in the fortunes of the Institution and the patients committed to its care.

In accordance with the usual custom, the Hospital was inspected, on the 29th June last, by Lord Stradbroke and the late Mr. Clutton, on behalf of King Edward's Hospital Fund for London, and the amount of the grant for the year subsequently made by the Council would seem to show that the Authorities of the Fund are satisfied with the condition and progress of the Institution.

After sympathetic references to those members of the Governors and Staff who were lost to us by death during 1909, Mr. Bonsor's report continues with a general statistical statement of the number of patients treated in the hospital:—

PATIENTS.

Statistical tables regarding In-patients and Out-patients, their numbers, categories, cost, and other details, are published on pages 64 to 67 of the Report. The figures are again presented in the form required by King Edward's Hospital Fund for London, and on comparison with those of the previous year show a decrease in the number of available beds (from 620 to 617), due to alterations in Addison, Lazarus and Stephen Wards respectively; a substantial rise, constituting, as already stated, a record in the number of In-patients accommodated, and a comparatively small, but not unwelcome, diminution in the number of Out-patients.

With regard to the 8,933 In-patients treated during the year, 533 were in residence on the 1st January, 1909, and 8,400 were admitted to the Wards during the course of the year. After treatment, 7,304 In-patients were discharged as cured or relieved, 436 as unrelieved, and there were 705 deaths, a near comparison with the mortality of 701 in 1908. The cases were divided into 2,992 of a Medical, and 5,941 of a Surgical nature, this showing, compared with the previous year, an increase in both categories. The number of beds in daily occupation decreased from 529·8 to 525·6, but the average mean residence of patients in the Medical Wards decreased, as compared with the previous year, from 37 days to 33·4 days, and in the Surgical Wards from 18·3 days to 17·5 days, thus permitting of the increased number of patients benefited. Accident cases admitted to the Wards numbered only 1,064, a diminution which, compared with the record number of 1,309 in 1907, and 1,228 in 1908, and the numbers in previous years, calls for mention. Of the sufferers from accidents 76 died in Hospital.

Then follows a list of the number of patients sent to various convalescent homes after leaving the hospital,

which was published in the GAZETTE of January 22nd this year. The report remarks as follows on the general subject of convalescent homes:—

The increased benefit to the patients resulting from the co-operation of Country and Seaside Homes with Town Institutions can be readily appreciated. Guy's Hospital does not possess a Convalescent Home of its own, nor have the Governors pursued the idea of one, believing that greater good is accomplished by distributing patients, according to the physical need of the individual, among existing Convalescent Homes. To the Authorities of the Homes the Governors tender once more their hearty thanks for the valuable help thus rendered, with special acknowledgment to those who, by receiving the patients free of charge, relieved the resources of our Samaritan Fund.

OUT-PATIENTS.

The number of new Out-patients, arrived at after deducting admissions to Wards from Surgery and Out-patients, and transfers from the Surgery to the Out-patients' and Dental Departments, reached a total of 130,499, a decrease of 1,789 on the previous year. The result was due to fewer Casualty Patients 80,975, compared with 83,638 in 1908, a decrease in General Medical and Surgical cases, Aural and outside Maternity cases, and an increase in the other Special Departments devoted to Dental, Obstetric, Ophthalmic, Skin, Throat and Orthopædic cases. The figures form a good illustration of the fact that the Out-patients' section of Guy's Hospital is successful in checking abuse of its ministrations, avoids improper competition with general Medical Practitioners, and in increasing degree fulfils its true function of "the poor man's Consultant."

FINANCE.

The main paragraphs on this important subject are as follows:—

The Income and Expenditure Account, as already indicated, shows a balance to the good. The total income, Ordinary and Extraordinary (excluding the Re-endowment and the New Out-patient Department Funds), amounted to £81,005 4s. 5d.; total Ordinary Expenditure to £66,943 4s. 11d., and as Extraordinary Expenditure under the Revised Uniform System is not shown on this account, the excess balance of income for the year amounted to £14,061 19s. 6d. Out of this surplus, however, the Governors were enabled to discharge the remaining cost on Extraordinary Capital Expenditure of the New Out-patient Department and other works amounting to £9,615 0s. 3d., the balance of £4,446 19s. 3d. being carried to the credit of capital.

The total income above mentioned was made up as follows:—From net Rents as per Revenue Account, £28,338 0s. 10d.; net Dividends, Rents and Interest arising from the investments of the Re-endowment Fund, £10,432 10s. 9d.; King Edward's Hospital Fund for London, £9,000; Donations, £8,931 18s. 7d.; Annual Subscriptions, £3,356 10s. 0d.; Hospital Sunday Fund, £1,679 3s. 4d.; Hospital Saturday Fund, £252; Legacies for general purposes, £11,264 5s. 3d.; Patients' Payments, £5,737 1s. 11d.; Nurses' and Probationers' Fees, £1,223 1s. 9d.; Return of Income Tax, £536 6s. 4d.; and Sundry Receipts, £254 5s. 8d.

(To be continued.)

Sport.

Lawn Tennis.

The prospects for the coming season are by no means as bright as usual. Owing to the extraordinarily wet weather of late the trial matches had to be abandoned, and consequently no new good men have been found. We regret that the services of our Captain, H. Sharpe, will not be available for part of the season through his unfortunate illness, and we wish him a speedy recovery. With a stronger fixture list than last year, however, and strenuous practice, we hope to retain both the Inter-Hospital Cups.

FIXTURES.—FIRST VI.

May	7	S.	Blackheath	Home.
	12	Th.	Norhyrst (1st round Surrey Cup)	Home.
	14	S.	Caius College, Cambridge ...	Away.
	18	W.	Mr. J. Ganzoni's VI.	Home.
	21	S.	Redhill	Home.
	25	W.	... ...	
	28	S.	Dulwich Farm	Home.
June	4	S.	Surbiton "A"	Home.
	8	W.	... ...	
	11	S.	Balliol College, Oxford	Away.
	18	S.	Kent	Home.
	25	S.	Finchley	Home.
July	2	S.	Redhill	Away.
	6	W.	Blackheath	Away.
	9	S.	Walton and Hersham	Away.
	16	S.	Dulwich Farm	Home.
	23	S.	Surbiton "A"	Away.
	30	S.	Kent	Away.

SECOND VI.

May	7	S.	Watford	Away.
	14	S.	Downing College, Cambridge ...	Away.
	21	S.	Malden (1st round Surrey Junior Cup)	Away.
	25	W.	Middlesex Hospital	Away.
	28	S.	King's College Hospital ...	Away.
June	1	W.	St. Mary's Hospital	Home.
	4	S.	Chiswick and West London ...	Away.
	11	S.	Hertford College, Oxford ...	Away.
	15	W.	St. Bart.'s "A"	Away.
	18	S.	St. Mary's Hospital	Away.
	25	S.	Woking	Away.
July	2	S.	Wimbledon "A"	Home.
	6	W.	King's College Hospital ...	Home.
	9	S.	Watford	Home.
	13	W.	St. Thomas's "A"	Home.
	16	S.	St. Thomas's "A"	Away.
	20	W.	Middlesex Hospital	Home.
	23	S.	Woking	Home.
	27	W.	St. Bart.'s "A"...	Home.
	30	S.	Chiswick and West London ...	Home.

Births.

CHASE.—On Thursday, May 12th, at Sewardsley, Chesterfield, the wife of Dr. Chase, of a daughter.

RICHARDSON.—On May 8th, at "Melbury," Boscombe, Bournemouth, the wife of W. Silverwood Richardson, F.R.C.S. Edin., of a daughter.

Death.

RICHARDSON.—On May 8th, at "Melbury," Boscombe, Bournemouth, Ada Mary, the beloved wife of W. Silverwood Richardson, F.R.C.S. Edin.

Ed.—A. N. C.

GUY'S HOSPITAL GAZETTE.

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Calendar of Coming Events and Ensuing Take-in Weeks.

May.

Sat. 28. Cricket—1st XI. v. Bexley Asylum (Away).
2nd XI. v. Hampstead Nomads (Home).
Tennis—1st VI. v. Dulwich Farm (Home).
2nd VI. v. King's College Hospital (Away).

Mon. 30. Clinical lecture by Mr. Targett (Gynæcology), 1.15 p.m.

June.

Thur. 2. Messrs. Dunn and Rowlands' Take-in (Messrs. Lucey and Francis).

Sat. 4. Guy's Hospital Athletic Sports, Honor Oak Park, 2.30 p.m.
Tennis—1st VI. v. Surbiton "A" (Home).
2nd VI. v. Chiswick and West London (Away).

Mon. 6. Clinical lecture by Mr. Eason (Ophthalmology), 1.15 p.m.

Tues. 7. Examinations for Treasurer's Gold Medals begin.

Thur. 9. Sir Alfred Fripp and Mr. Turner's Take-in (Messrs. Brown and Elliott).

Passim.

THE next and succeeding issues of the GAZETTE will be published and sent out to subscribers on Friday instead of Saturday as heretofore. This change has been made by the Committee in response to the wishes of some colonial readers, who have pointed out that in this way they will in some cases receive their GAZETTE a week earlier, as the mails to several of the colonies go out on Saturday morning. We have, therefore, to remind contributors and the secretaries of the various clubs that in future their contributions should be sent in a day earlier, that is, on or before Tuesday in the week in which the GAZETTE is published.

IT is our pleasant duty to congratulate Mr. A. S. B. Bankart, M.C., F.R.C.S., our late Surgical Registrar, on his appointment as Assistant Surgeon to the Belgrave Hospital for Children, to fill the vacancy caused by the resignation of Mr. Philip Turner.

IF any of our readers possess public spirit and old surgical instruments, they should turn to the correspondence column, and read there the instruments which Dr. Cock is asking for, in order to fill gaps in the collection of old instruments which "adorns" the Gordon Museum. The thanks of all Guy's men are due to Dr. Cock for the large amount of trouble he has taken in getting together this most interesting collection, as well as for his numerous personal gifts to this section of the Museum. The

collection now outshines in historical interest both that in Coles' cupboard and that shown to candidates in the College exams. For details of instruments which are still wanted in the Museum collection, we refer our readers to Dr. Cock's letter in the correspondence column.

MR. THOMAS BRYANT, our Consulting Surgeon, was unavoidably prevented from taking part, as one of the late King's honorary surgeons, in the funeral procession from Buckingham Palace to Westminster Hall on May 17th. Sir Alfred Fripp was present in the procession as one of King Edward's Surgeons in Ordinary.

FULL particulars of the Guy's Annual Sports, which are to be held on Saturday, June 4th, are announced in the correspondence column. We have been asked to call attention also to another athletic meeting—that of the University of London Athletic Union—which is to be held at Stamford Bridge on Thursday, June 16th. Mr. H. W. Evans, the Guy's representative, desires it to be known that all students of the hospital are eligible for membership of the Union, and that, as Guy's has been well represented in the sports in the past few years and done very well in them, it is hoped that this year the new men will take a practical interest in them, so that Guy's may retain the first place among the colleges which it gained last year.

AT the recent Primary Fellowship Examination there were 135 candidates, of whom 73 per cent. were referred. That is more impressive than saying that 27 per cent. passed. Of candidates from Guy's, we are pleased to say that no less than seven were successful. The recent examination was the first to which women candidates were admitted, and of the six who entered one was successful.

THE large and regular attendance at Dr. Hertz's demonstrations on selected cases from his Neurological Out-patients has shown very clearly that the usefulness of this form of clinical teaching has been fully appreciated by students. Indeed, these Wednesday morning demonstrations have become quite a popular weekly event in the hospital, showing once again that students will attend what they find to be good for them, without the humiliating spur of compulsory "signing up" being applied to them by examination authorities. Such practical proofs as this that students are reasonable creatures ought to have far more weight with examination authorities (which we must suppose would claim to be reasonable bodies), than the arguments in the shape of rotten eggs and tomatoes which our brothers in Paris have lately been placing before *their* examination authorities, apparently with some success.

To return to the subject of Out-patient demonstrations, we should like to see this method of teaching applied to some of the other departments. To many men reading for their finals, and to men coming up to the hospital for post-graduate study, such demonstrations, held on selected cases at a fixed hour, would have far more educational value than the ordinary Out-patients, where they may have to wait through the whole of a long afternoon, seeing numerous commonplace cases, of but slight interest from their point of value, with only an occasional exception. The clerks and dressers at ordinary Out-patients would benefit by such a plan, as the unwelcome crush of "outsiders" would be removed to the special demonstrations. We hope that this system of demonstrations on selected cases, which has an established place in clinical teaching on the Continent, may be applied to some of the other Out-patient departments at Guy's.

BOOKS RECEIVED.—Number 6, vol. iii., Proceedings of the Royal Society of Medicine; Lluria's Super-Organic Evolution; The Imperial Yeomanry Hospital in South Africa—Presented by Earl Howe.

The Annual Report.

FINANCE—*continued.*

Compared with the corresponding figures for 1908, the total Ordinary Income of £69,740 19s. 2d. shows an increase of £6,870 14s. 10d., a result principally due to a munificent anonymous donation of £5,000, an increase of £1,500 in the grant from King Edward's Hospital Fund for London, and an augmented income from the Re-endowment Fund. On the other hand, the depreciation in the revenue from the older endowments, to which reference was made in the previous Report, has continued through the reduction of rents and loss of tenants from the warehouses which form the principal part of the Southwark Estate of the Hospital, and which at one time was perhaps its surest source of revenue. Extraordinary Income, which consisted entirely of Legacies, amounted to £11,264 5s. 3d., compared with £8,617 16s. 2d. from the same source in 1908.

The total Ordinary Expenditure for the year amounted to £66,943 4s. 11d., compared with £65,775 15s. 9d. in 1908, the increase being mainly due to higher prices under the heading of Maintenance in respect of Provisions, and Surgery and Dispensary requirements.

The New Out-patient Department Fund, published on page 91, is now closed. The total cost of the undertaking amounted in the end to £30,314 11s. 7d., as appears on the Balance Sheet, this sum including certain expenditure additional to the original estimate of £21,600 mentioned in the Report for the year 1907, in consequence of necessary extensions and alterations in plans. It will be remembered that the bulk of the required capital expense was munificently provided by an anonymous Donation of £10,000, and by a special grant of a like amount from King Edward's Hospital Fund. During last year a contribution of £1,000 was received from "J. M.," that generous friend who has so greatly assisted the various needs of the Hospital from time to time, and the balance of the total cost was met, as already stated, out of the surplus arising on the general income of the Hospital for the year.

Recent events lend a melancholy interest to the following paragraph, when it is remembered that our late King, when Prince of Wales, inaugurated the Re-endowment Fund, which is referred to :—

The Re-endowment Fund, which at December 31st, 1908, amounted to £281,421 5s. 5d., received a total addition during the year of £23,315 2s. 1d., mainly the result of the testamentary benevolence of the Rev. Walter Howse, who during his lifetime had contributed largely to the needs of the Hospital, and at his death bequeathed to this Fund the whole of his Residuary Estate amounting to £22,613 10s. There was also received a gift of £300 Western Australia 3½ % Stock from Wolf Harris, Esq., a further instalment of £100 from Henry Lafone, Esq., and among other contributions one of £35 0s. 5d. from Mrs. Henderson, a further result of her kind and sustained efforts to endow a cot in perpetuity, an object which is now within measurable distance of being achieved, the total sum received for the purpose up to the end of 1909 being £312 19s. 2d. The Re-endowment Fund was also augmented by a surplus balance of £170 9s. 4d., being placed to its credit by the Trustees of Guy's Hospital Children's Home, at Forest Hill, on the closing of that Charity ; bringing the total of the Fund at the end of the year, since its inauguration in 1896, to £304,736 7s. 6d., which amount is represented by Investments at cost, as set out in the Account of the Fund on pages 48, 49.

Subsequent sections describe the year's record in the Nursing Department and in the Medical and Dental Schools. The following paragraphs, under the heading *Administration, are of special interest* :—

ADMINISTRATION.

Of chief importance under this head has been the completion and occupation in October last of the new Out-patient Departments. The work is the result of an almost complete reconstruction of the old Department, and the addition of new buildings. The alterations in the old premises consisted of the removal of dividing walls ; the laying of concrete and mosaic floors in place of wood ; the tiling of walls ; addition of new rooms for the Obstetric Department, Ambulance Service, accommodation of Sisters and Nurses on duty ; and the construction of extra Lavatories and new Main Entrance. The scheme included the erection of a tower, which provides operating rooms for Addison, Stephen, and Bright Wards respectively ; also Bathrooms connected with the dormitories, occupied by Ward Maids, on the roof of Hunt's House.

The new building provides accommodation on the ground floor for the Surgery and Casualty Department (transferred from the front of the Hospital in St. Thomas's Street) ; on the first floor for Dental Extraction Cases ; on the second floor for Throat and Ear Cases ; on the third floor for Eye Cases ; also rooms for the Resident Surgical Officer, Dressers and Assistants. Without display, everything has been done to achieve practical and beneficent ends. The whole is now in working order, and the treatment of patients greatly facilitated. Perhaps the most striking change to those familiar with the Hospital in the past will be found in the abolition of the historic Front Surgery ; but sentimental reasons apart, the concentration of all the principal classes of Out-patients will prove a great advantage to all concerned. The present opportunity is taken of directing attention to the fact that practically all patients are now received at the entrance to the hospital in the street called Maze Pond.

A plan of the alterations and additions to the Out-patient Department is enclosed in the Report.

The Report closes, as usual, with the very important subject of

THE FUTURE.

In the firm trust that the general needs of the Charity will continue to be supplied in present sufficiency, the Governors contemplate measures for the early accomplishment of further necessary works. Some of these,

the rebuilding of Clinical House, including an increase of beds for Special Departments and the provision of separate Wards for Children, were mentioned in the previous Report. A fuller list comprises, *inter alia*, a new Operating Suite, new residences for certain Officers and Servants of the Hospital required to be at all times available for emergencies, and an extension of the Henriette Raphael Nurses' Home to meet an inevitable increase of Staff, and these latter works, because of their urgency, the Governors have been compelled to undertake without further delay. The cost of the whole scheme of improvement and extension will, it is estimated, be covered by the £60,000, for which a preliminary appeal was issued twelve months since. No specific donations in response had been received at the close of the year, but a 1910 Building and Renovation Fund designed to meet the case has now been formally opened, and the Governors venture to hope will receive the same ready and cheerful support as its predecessors. The Governors, as Trustees, vouch for the necessity of these things to efficiency and progress, and earnestly commend them to the most generous consideration of all who recognise the increasing service to our common humanity demanded, yet rightly demanded, from the Hospital of Thomas Guy.

Appointments.

Civil.

BANKART, A. S. BLUNDELL, M.C. Cantab., F.R.C.S. Eng., has been appointed Assistant Surgeon to the Belgrave Hospital for Children.

HERTZ, ARTHUR F., M.D., B.Ch. Oxon., F.R.C.P. Lond., has been appointed Physician for Nervous Diseases, with Charge of Out-patients, at Guy's Hospital.

MINETT, E. P., M.R.C.S. Eng., L.R.C.P. Lond., D.P.H. Cantab., M.B. Brux., has been appointed Assistant Government Bacteriologist in British Guiana.

MOLLISON, W. M., M.C. Cantab., F.R.C.S. Eng., has been appointed Aural Surgeon to Guy's Hospital.

SCALES, J. E., L.R.C.P. Lond., M.R.C.S. Eng., has been appointed Medical Officer and Public Vaccinator for the Kilmersdon District by the Frome (Somerset) Board of Guardians, and for the Radstock District of the Clutton (Somerset) Union.

THOMPSON, RALPH, F.R.C.S. Eng., has been appointed Surgeon to the newly-established Genito-Urinary Department at Guy's Hospital.

Naval and Military.

Surgeon C. G. SPRAGUE, R.N., is posted to the *Vivid*, additional, for disposal.

Territorial Force.

1st Southern General Hospital—Captain James W. Russell, to be Major (dated August 5th, 1909).

A Vision of The Peacemaker.

"Blessed are the Peacemakers, for they shall be called the Children of God."

Brooding upon my nation's loss and mine,
I saw—within those misty borderlands
That lie about the realms of reverie—
A stately fane whose shadowy dome rose dark
Against the purple of a starlit sky;
And, passing through its deep-set portals, found
A vast dim hall, groping wherethrough my way,
I, stumbling, trod upon some metal thing
That clang'd and rolled upon the paven floor;
I raised and found it a great cirque of gold,
Fretted and filigree'd and rich with gems:
It was that emblem of earth's loftiest state,
A crown, a king's, discarded and forgot.
Then, marvelling that so rare a thing should seem
So lightly lost, I passed to where a throne
Rose dim upon a daïs, and whereon,
Through high and rich-stained oriel window-panes,
Fell, filtering down, the light of many stars;
And in that soft suffusion then me-seemed
Faintly to trace a fluttering company
Of fairest children-forms, and in their midst
The King! Yet not the King, for young he seemed,
Young as themselves; the majesty of youth
Shone lightly o'er him, as, with glad farewell,
He glanced back on that ponderous, carven seat
Where once he sat, cumbered with many cares,
And worn with kingly service and the years.
Lightly he passed. Then murmured through my mind
That promise to the Peacemakers: that they
Should be, not great grave lords at last, decked out
With dignities, and laden with vast powers,
But—once again winning that paradise
Of light unclouded peace their childhood knew—
Children of God. And still I see the King,
The old King whom we loved, a lighfoot lad,
With eager eyes, quick smile, and clear bright brow,
And potent with the Child's vast potency,
See him as then I saw and knew my King,
Not by the mortal form, light even as youth,
But by some subtle sense whereby, I learnt,
Spirit may spirit greet and recognize,
Passing, ringed round with children, to his rest,
Passing, re-arm'd with youth, to loftier life.
Peacemaker, Child of God, hail and farewell!

HABBERTON LULHAM.

Ditchling, Sussex.

So-called Influenzal Attacks which are really Indicative of Phthisis.

BY HERBERT S. FRENCH, M.D. (OXON.), F.R.C.P. (LONDON).

ALL observers who have made phthisis a study are agreed that the great majority of cases run their course by a process which may be described as that of exacerbations with intermissions. These exacerbations and intermissions are obvious enough when a stage of the malady has been reached when there is little or no doubt as to the diagnosis, but it is too seldom recognised that long before there are definite abnormal physical signs in the lungs, and in many cases even before there are such definite symptoms as cough or hæmoptysis, the disease produces little outbursts of pyrexia associated with temporary lassitude which may last a few days or a week, and then pass off entirely for the time being, exactly like those attacks which have been again and again spoken of as influenza. It is far too easy to diagnose an attack of "influenza" and to consider that that diagnosis is final. Many attacks which are called influenza are really what the French call *pousses évolutives de la tuberculose*. The importance of recognising this is that if there is even the smallest quantity of sputum obtainable in such cases it should be examined carefully for tubercle bacilli as well as for the bacillus of influenza; for if tubercle bacilli can be found in it at an early stage when the patient exhibits no wasting, no night sweats, none of the severe toxic effects of phthisis and secondary infection of cocci, the adoption of suitable precautions may lead to almost immediate cure. It is too late to wait until there are definite physical signs, for phthisis may be diagnosed by microscopical examination for tubercle bacilli in the sputum at a much earlier date than that at which the changes in the lungs have been sufficient to produce definitely abnormal signs. One can hardly say too much in deprecation of the tendency there is to be satisfied with the diagnosis of "influenza" when the only evidence of the malady is a temporary pyrexia.

The *pousses évolutives* of established phthisis are characterised by a marked increase in both the general and the functional symptoms of the malady. Amongst these symptoms the temperature is of particular interest. A rise of temperature is the rule, and only in exceptional cases does the temperature remain normal. It is not a question of transitory rises, such as may be noticed in the evenings in tuberculous subjects after a fatiguing walk, for instance, but of definite cyclical curves; a period of rise, a period of maintained temperature, and a period of defervescence. The clinical types of these curves are very variable. In certain cases it is almost a matter of ephemeral elevation, or the thermal curve may show a more lasting rise, the temperature going rapidly up to 102° or 103° F., either at one leap or by two or three stages, maintaining these figures for ten days or a fortnight, and then falling again more or less by lysis. In yet other cases the thermic curve will extend over several weeks, producing a very elongated chart not unlike that of some cases of persistent typhoid fever. Generally speaking, in this last form the temperature rises slowly to a maximum about which it remains for a longer or shorter time, and then falls with extreme slowness, and in certain cases in which defervescence is very pronounced the cyclical curve may not become obvious until reduced charts extending over several months can be obtained. In this form the defervescence takes place so gradually that it may at any given moment seem as though there were no improvement at all, and yet the latter comes about when all hope seems to have been lost. Occasionally a thermic curve at the moment of defervescence presents quite a peculiar aspect like that of a ladder with very accentuated steps. Whatever may be the actual appearance of this pyrexial curve, it presents three main characters almost constantly: it is cyclical, it is of remittent type, and, generally speaking, it does not present a terminal hypothermia.

There may be many different intercurrent factors, especially secondary infection of cavities of the lung by pyogenic cocci, which interfere with the curves; but not only in the earlier stages of phthisis, when there are as yet no phthisical signs, may there be *pousses évolutives* which are apt to be labelled "influenzal" but also in the later stages of the disease these *pousses évolutives* are often still apparent.

Parallel with the temperature characters the arterial blood-pressure shows changes of some interest. At the moment of the *pousses évolutives* the arterial blood-pressure, which is always low in tuberculous subjects, falls still more, and may reach such figures as even 10, 9, or 8 of Potain's sphygmomanometer. The end of the *pousse* is, on the contrary, marked by a slight rise of the blood-pressure up to 12 or even 14, though in the majority of cases it rises only with extreme

slowness and always remains below the normal. There is, nevertheless, as in any other infectious malady, a fall of pressure in the first instance, followed by a definite rise at the moment of convalescence.

The patient at the same time exhibits exacerbations in his other symptoms and physical signs. There is often a temporary increase in the sputum. If phthisis has reached a stage at which there is already a more or less abundant expectoration at the moment of the *pousse*, there may be an increase in the quantity of this expectoration without material change in its characters; in other cases the sputum becomes more purulent, and often it develops a viscosity which makes it more or less adherent to the side of the vessel into which it is put; sometimes it develops an amber-yellow colour and a slightly translucent aspect which is almost typical, and it may even become so like that of ordinary pneumonia that unless a microscopical examination is made, an error of diagnosis may occur although tubercle bacilli are present in large numbers. Sometimes the patient is one who has had no expectoration at all previous to the onset of the *pousse;* one then notices that he begins to bring up a small amount of purulent sputum for a short time, and possibly even only for a single day. It is very easy in such cases to imagine that the expectoration comes from the back of the nose or from the pharynx. The chief feature of the microscopical change in the sputum during a *pousse* is the marked increase in the number of tubercle bacilli it contains. This increase of the latter may be quite ephemeral, but if carefully looked for it is nearly always marked. Quite a number of these patients never spit blood at all; but in a few instances one notices how the hæmoptysis, slight though it is, is definitely related to the *pousses évolutives*. The great danger is that the cause of such a *pousse* may be overlooked, and that it may be mis-diagnosed as "influenza" unless care be taken never to diagnose influenza except when there can be no doubt about it.

Papers by Guy's Men.

C. Gordon Douglas, M.B., B.Ch., and J. S. Haldane, M.D., LL.D., F.R.S.: The Causes of Absorption of Oxygen by the Lungs.—*British Medical Journal*, May 14th, 1910.

E. I. Spriggs, M.D. Lond., F.R.C.P. Lond.: An Address on the Treatment of Gastric and Duodenal Ulcer.—*British Medical Journal*, May 21st, 1910.

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

The Biennial Dinner, July 1st, 1910.

DEAR MR. EDITOR,—I should be glad if you would again afford me the opportunity of referring in your columns to the Biennial dinner.

The replies to the invitation issued at the beginning of this month have been very satisfactory, as, in addition to the thirty Vice-Chairmen whose names are appended below, the following have already intimated their intention to attend:—

Adeney, E. L.
Ashwin, R. H.
Austen, H. H.
Beale, E. Clifford.
Beard, F.
Beddard, A. P.
Black, G.
Blatherwick, H.
Bosworth, J. R.
Bowen-Jones, L. M.
Brailey, A. R.
Brailey, W. A.
Brookhouse, C. T.
Brookhouse, H. O.
Brown, Thomas.
Bryant, Thomas.
Burghard, F. F.
Buxton, A. St. Clair.
Cameron, H. C.
Cardin, H. C.
Chisolm, R. A.
Cloud, F. H. L.
Cock, F. W.
Counsell, H. E.
Crofts, A. D.
Daldy, A. M.
Digby, K. H.
Dunn, L. A.
Durham, F.
Elcum, D.
Elphinstone, R.
Ewart, J. H.
Eyre, J.
Fagge, C. H.
Fawcett, J.
Flower, N.
Forsyth, D.
Fothergill, E. R.
Fremantle, F. E.
Goadby, K.
Golding-Bird, C. H.
Goss, J.
Handley, W. S.
Hertz, A. F.
Higgins, C.
Howell, T. D. J.
Hughes, E. C.
Jones, C. E. M.
Key, M. Aston.
Laidlaw, P. P.
Lansdown, R. G. P.
Layton, T. B.
Little, E. Graham.
Lund, H.
Malleson, H. C.
Mann, H. C.
Mansell, E. R.
Matcham, A.
Minns, P.
Mollison, W. M.
Nash, W. G.
Newnham, W. H. C.
Nicholls, F. J.
Nichols, R. T.
Ormond, A. W.
Pavy, F. W.
Perry, E. C.
Pinching, Chas.
Randall, P. N.
Rippmann, C. H.
Roberts, A. C.
Robinson, W. E.
Rowland, E. W. S.
Rowland, W. J.
Savage, G.
Shaw, L. E.
Shipway, F. E.
Smith, D. W.
Starling, E. A.
Stevens, T. G.
Stewart, H. M.
Targett, J. H.
Taylor, J. G.
Thomas, J. D.
Thomas, T. P.
Turner, George.
Uhthoff, J. C.
Vandermin, H. F.
Vicars, F.
Way, M.
White, W. Hale
Woodhouse, C.
Young, F. C.
Younger, E. G.

I should be very much obliged if those who propose to come, and have not yet filled in and returned to me the application form sent them, would do so *as soon as possible*. This application form is one of the most

important means of securing the success of the dinner, as nothing is more likely to induce a doubtful man to decide to come than to see the names of friends who have already accepted. In the next number of the Gazette I hope to publish a large list of additional acceptances.

Many letters of sincere regret have reached me from old Guy's men who, perhaps on account of advancing age, or it may be of illness, are prevented from attending this year, but who nevertheless write to wish us an enjoyable and successful evening, encouraged to do do so by pleasant memories of past "Biennials," their letters being obviously tinged with a feeling of sadness that they themselves will not be with us in 1910 to add another "Biennial" to their list. In stating names of friends whose presence is particularly requested at the dinner, it would be a help to me if the initials were always added.

For the benefit of those who have mislaid their application form, a duplicate for use is to be found in the advertisement columns of this number of the Gazette, or a second form will be sent at once on application to me.—I am, Sir, yours sincerely,

JOHN FAWCETT.

66, Wimpole Street, W.
May 25th, 1910.

The following old Guy's men have promised to act as Vice-Chairmen:—J. Rand (Surbiton), 1858*. E. R. Ray (London), 1863. C. Sangster (Lambeth), 1867. W. H. Jalland (York), 1870. C. W. Pinching (Gravesend), 1873. H. Davy (Exeter), 1877. L. Stokes (Blackheath), 1881. R. M. H. Randell (Beckenham), 1884. A. S. Taylor (Surbiton), 1886. C. F. Routh (Southsea), 1887. J. Pendlebury (Ormskirk), 1889. H. L. E. Wilks (Salisbury), 1891. G. Sichel (Sevenoaks), 1892. H. Cooper (Surbiton), 1893. H. A. Munro (Catford), 1894. W. Tyson (Lowestoft), 1895. W. E. Hills (Hampstead), 1896. E. F. Clowes (Wotton-under-Edge), 1897. L. H. McGavin (London), 1898. A. A. Miller (Sutton), 1899. P. W. L. Camps (Teddington), 1900. F. G. Cross (Kingston), 1901. H. A. Cutler (Walton-on-Thames), 1902. A. R. Brailey (London), 1903. G. A. Ticehurst (St. Leonards), 1904. O. V. Payne (Alton), 1905. E. Morgan (Sketty, Glamorgan), 1906. W. W. Cook (Norwich), 1907, and H. R. Mullins, 1909 (*President of the Residents, April to June, 1910*).

* Date of Qualification.

The Hospital Sports.

Sir,—We should be glad if you could make it known in your columns that the Annual Athletic Sports will be held at Honor Oak Park on June 4th, commencing at 2.30. Entries are above the average, both in numbers and quality, and a really excellent afternoon's sport is anticipated. The R Division of the Police Band will play during the afternoon. Mrs. Ernest C. Hughes has kindly consented to distribute the prizes at the close of the meeting. Many gentlemen on the Staff will officiate as judges, and it only remains for the men to turn up in large numbers and so prove to the committee of the Athletic Club that their efforts to further the interest in athletics at the hospital have not been in vain. Tickets of admission, if purchased before the day, may be obtained from any member of the committee, price 6d. each. Thanking you, we remain, Yours truly,—

H. T. RENTON
A. B. DANBY } *Hon. Secs.*

The Historical Section in the Museum.

Dear Sir,—I have just placed in the museum a very interesting addition to our collection of ancient surgical instruments. It is a case of minor surgical instruments formerly belonging to the late Mr. George Tatham, who won it in 1830 as the anatomy prize at Guy's. We are indebted to his nephew, another old Guy's man, Mr. James Howell, of Wandsworth Common, for the gift, through the kind offices of Mr. Charters Symonds.

This announcement gives me the opportunity of once more stirring up our old students and friends. It is more than five years ago since I asked for that form of trepan which is used like a carpenter's stock and bit. We have a fairly representative series of the ordinary corkscrew-handled type. The other form, which was in use during the whole period 1550–1800, but less frequently than the latter, is rarely to be met with in England. It has recently been made again here, and was to be seen in foreign catalogues as lately as 1850. I want, too, early amputating knives, especially those of billhook form, and early-shaped catlins (double-edged knives) with lignum vitæ handles having a butt to them. A shagreen and silver pocket case, with its contents, would make a brave show. No self-respecting surgeon was without one when George III. was King. There must be many such relics eagerly waiting to be delivered from the dusty seclusion of old surgery drawers, so that they may flourish in the full light of the Gordon Museum, and show the younger generation how few were the weapons that our ancestors required in the days when dressings consisted of anything from lint soaked in "oil of whelps," alternating with solutions of indefinite salts of copper, down to the time when Liston did away with those "beastly poultices" and substituted simple water dressings. During this whole period it may be remembered that the cleanest thing at an operation was the unwashed skin of the patient.

Now, Sir, give them a preliminary flourish in "Passim," which will make them turn over the leaves, and then attend to the wants of—Yours truly,

F. WILLIAM COCK, M.D., F.S.A.,
Hon. Antiquary to the Museum.

1, Porchester Houses,
Porchester Square, W.
May 13th, 1910.

"Wigmore" Nasal Douche.

Sir,—Messrs. Allen & Hanburys are making for me a simple Rubber contrivance for irrigating the nasal passages which they have registered as the "Wigmore"

Nasal Douche. I have made use of the douche for some months in my practice and find it answers admirably.

It has the following advantages:—

1. Children use it easily and without making a mess. Its simple appearance does not cause them alarm.
2. The lotion passes at inspiration through the nasal passages without discomfort or shock.
3. A good quantity of lotion can be employed, as is often necessary, without danger to the Eustachian tubes.
4. There is nothing to break, and the douche can be easily cleaned or sterilized.

I have found the douche very useful in treating common nasal catarrh, the lotion employed being a weak solution of common salt and carbonate of soda. Those who suffer from attacks of "Cold in the Head," will find a daily irrigation with some such simple lotion an excellent preventive measure.—Yours faithfully,

Croydon, 14th May, 1910. A. PERCY ALLAN.

Change of Address.

W. H. Bowen, M.S. Lond., F.R.C.S. Eng., from 60, Harley Street, W., to 5, Gresham Road, Cambridge.

E. B. Hinde, M.B., B.C. Camb., from the Great Northern Central Hospital, Holloway Road, N., to c/o 69, Thorpe Road, Norwich.

F. Morres, M.R.C.S., L.R.C.P., to Saint George's Infirmary, Balham Road, S.W.

Donald J. Munro, M.B., B.S. Lond., from 56, Acre Lane, Brixton, to 169, Brixton Hill, Brixton, S.W. (Teleph. Brixton 505.)

W. M. Robson, M.D. Lond., from 68, Abingdon Street, Northampton, to 73, St. Giles' Street, Northampton.

J. E. Scales, M.R.C.S. Eng., L.R.C.P. Lond., from Tyn-y-Pistyll, Llanferris, Mold, to Leigh House, Radstock, Somerset.

J. T. Smalley, M.R.C.S. Eng., L.R.C.P. Lond., from Guy's Hospital to Suva, Fiji.

Notice.

His Majesty's Indian Medical Service.

A competitive examination for not less than fifteen appointments to His Majesty's Indian Medical Service will be held at the Royal Army Medical College, Millbank, S.W., and at the Examination Hall, Victoria Embankment, London, on the 25th July, 1910, and five following days.

Copies of Regulations for the examination, together with information regarding the pay, retired pay, etc., of Indian Medical Officers, can be obtained on application to the Military Secretary, India Office, London, S.W. Application for admission to the examination, with the necessary certificates, must be sent so as to reach him on or before the 12th July, 1910.

Programme of Examination.

Examiners.—Dr. T. D. Acland, M.A., M.D., F.R.C.P., in Medicine and Therapeutics; Mr. F. J. Steward, M.S., F.R.C.S., in Surgery and Diseases of the Eye; Professor A. Thomson, M.A., M.B., F.R.C.S., in Applied Anatomy and Physiology; Professor E. J. McWeeney, F.R.C.P.I., in Pathology and Bacteriology; Professor M. Cameron, M.D., in Midwifery, Diseases of Women and Children; Dr. F. D. Boyd, C.M.G., M.D., F.R.C.P. (Edin.), in Materia Medica, Pharmacology and Toxicology.

At the Royal Army Medical College, Millbank, Monday, 25th July, 1910, Practical Pathology, from 2.30 p.m. At the Examination Hall, Tuesday, 26th July, 1910, Clinical Medicine and Examination of Specimens,* from 10 a.m.; Paper in Medicine and Therapeutics, from 2 to 4 p.m.; Paper in Surgery and Diseases of the Eye, from 4.30 to 6.30 p.m. Wednesday, 27th July, 1910, Clinical Surgery, from 10 a.m.; Paper in Pathology and Bacteriology, from 2 to 4 p.m.; Paper in Applied Anatomy and Physiology, from 4.30 to 6.30 p.m. Thursday, 28th July, 1910, Clinical Surgery, from 10 a.m.; Paper in Materia Medica, Pharmacology and Toxicology, from 2.30 to 4.30 p.m.; Paper in Midwifery, Diseases of Women and Children, from 5 to 7 p.m. Friday, 29th July, 1910, Surgical Operations, from 9.30 a.m.; Oral Examination (half of the candidates), from 2.30 p.m. Saturday, 30th July, 1910, Oral Examination (remainder of the candidates), from 9.30 a.m.; Examiners to meet in conference on termination of the examination.

* Candidates will be required to examine and report in writing upon microscopic and macroscopic specimens to be presented by the Examiners in Medicine, Surgery, Physiology, and Pathology. The reports will be made on forms supplied for the purpose, and one hour will be allowed for the four reports.

BEAUCHAMP DUFF, Lieutenant-General,
Military Secretary.

India Office, Whitehall, S.W.
May, 1910.

In Lighter Vein.

EXTRAORDINARY INCIDENT.

STAFF TAKE PART IN SUFFRAGETTE RAID.

VIVID DETAILS.

ALTHOUGH it is well known that the entire Staff, with the exception of Mr. Thompson and Master Bunch, are in favour of Women's Suffrage, no details have, so far, leaked out as to their part in a recent raid on the Houses of Parliament.

The attack had been organised by Drs. Turner and Hughes, at whose instigation almost the whole Staff had turned out, attended by no less an expert in Suffragette lesions than Dr. Francis himself. He had, moreover, brought an ambulance and his assistant, Mr. Ormond.

No sooner were they all arrived in Parliament Square than a determined effort was made, in concert with a number of Suffragettes, to reach the door of the House. This having failed, a meeting was at once held to decide on a course of action. Mr. Beddard, whose hat was noticed to have been knocked straight in the struggle, said that he personally could see no reason why every jack woman should not have the vote, or anything else, t.d.s. He was sure it was perfectly harmless. Dr. Dunn seconded the motion, and addressing himself to the female half of his audience, said, "There, my dears, look at you." This sounded so convincing that it was immediately adopted as a war cry, and a fresh onslaught was made on the House. The R.S.O., whose winning smile has done so much to relieve the tedium of the nurses' sick room, successfully imitated Dr. Dunn, only more so. Before long he found himself the centre of an admiring crowd whose chins he dutifully chucked with an affectionate "You thing, you." [Rumour has it that having chucked one lady labelled Christabel *twice* under the chin, that lady swore she would bring him to book or the altar.]

In the struggle which ensued it was observed that while Dr. Lane applied lion forceps to what was left of a policeman he had encountered, and Mr. Hertz declaimed, in a mixture of Low German, Highland Scotch, Hindoo Dutch and Nasopalatine American, on the advantages of Bismuth over Bovril, Messrs. Pitt and Fawcett stood apart discussing the morbid pathology of the malignant forms of suffragette. Sir Perry Cooper, who was arrested for attempting to knock off a policeman's helmet, gave his address as "Superintendent's House, Guy's Hospital," and remarked that "he thought they were sports in the City." At this moment a motor displaying the Royal Arms drew up close by, and out sprang Lord Alfred Fripp disguised as a commoner, but apologising in so charming a manner for being two hours late that his rank could not fail to show through the disguise.

Most of the Staff had been arrested by this time, and on the way to Cannon Row the prisoners tried to cheer each other with funny tales, Dr. Rowlands remarking that he had operated on two thousand and seventy-five cases without a death whatever, and Dr. Symonds recounting how, in eighty-one, two, three, he had seen four cases of——A low-pitched but sonorous "Quite, quite," interrupted him, and the sound was thought to have come from the neighbourhood of a tall female prisoner with bronzed complexion and speckled purple skirt resembling a flea-bitten kidney. Dr. Hughes, who had been secured early in the fray and had had his hands tied behind him with bandages supplied by Dr. Francis, protested against such treatment being meted out to a senior member of Guy's Staff, but his captor merely replied that they always treated the young boys that way. Murmurs of "married," "anatomy demonstrator," "Lock," etc., were stifled by a fist the size of a growth of the cæcum. Dr. Eyre had joined the procession out of *ésprit de corps* alone, for, as he remarked, since he could pass through a Berkefeldt, it was hardly likely that a policeman could detain him. His freedom seemed to annoy Dr. Fagge, whose cherubic countenance had lost its smile, and had he not been shackled to a constable nearly twice his own weight, it is thought that his threats of smashing John Eyre with his niblick might have been carried into effect.

In the meantime, word had been sent to the hospital that the Staff were in need of persons who would go bail for them, and it was pointed out that these should be householders, and preferably churchwardens.

Hancock was the first to arrive, and he made some unintelligible remark about being good up to sixpence for Joey if he managed to beat the boys at penny in the skull next week. He then put his name down against that of Dr. Hughes, and appeared to imagine he would get the "head and neck."

On the arrival of the Matron, accompanied by Grey and Bell, a scene of wild excitement ensued, as each prisoner clamoured for bail to

be allowed them. Grey at once released Mr. White and Dr. Symonds, and then went home. Bell secured that no more spinal cords were wanted, and then went bail for Mr. Pitt. He said the same would apply to Messrs. French, Fawcett and Hertz, and, in addition, brains must be barred on Mondays. The prisoners, who were ready to promise anything, were then released by Mr. Bell. Sir Perry Cooper was told he might go home, and Lord Alfred Fripp was escorted to the hospital by a guard of honour formed of the C Division. In the meantime, his H.S. had finished the operation, having opened and drained a septic finger.

Several of the Staff still remained unliberated, when Dr. Thompson turned up, and hopes rose high. A smell of burning sulphur soon dashed these to the ground, and in a voice of thunder came the uncomforting remark that since the —— fools had let themselves be awested, he —— well hoped they would all be hung. He had no doubt the —— hospital would be —— well better off without them. He then left, carrying away the head of a policeman's femur.

The Matron, who had hitherto stood aloof, now offered to go bail for the remainder, and this kind offer was accepted with alacrity by Messrs. Shaw and Beddard, and Drs. Lane, Dunn, Rowlands, Fagge and Steward. Dr. Francis, who gained the esteem of the entire police force by his clever treatment of fractures with aspirin, consented to bail out Dr. Eason. At this moment the Inspector, fixing his terror-stricken gaze on Dr. Turner, who was reclining on the floor, announced that that gentleman appeared to be dead, but the Matron reassured him with the statement that Dr. Turner had rarely looked so well as at this moment. As to treatment, she believed a long Whitbread would soonest bring him round.

By midnight the Staff were liberated, and, thanks to the heavy bribes offered to Grey, Hancock and the Matron, nothing has been heard of their adventures till now.

DADI.

Papers by Guy's Men.

A. Lawford Knaggs, M.C. Camb., F.R.C.S. Eng.: On Implantation of the Ureters into the Rectum by the Sacral Route. Illustrated by a Case of Inveterate Vesico-vaginal Fistula in which the left Ureter was implanted and the Right Kidney removed. — *British Medical Journal*, May 21st, 1910.

Nursing News.

Matron's Office.

Miss M. A. D. Collingwood, who completed her three years in January last, has been appointed Probationary Sister of Bright Ward.

Miss Edith Horsepool, who completed her training in 1903, has been appointed Matron of the Cottage Hospital, Abingdon-on-Thames. Since leaving Guy's, Miss Horsepool has done private nursing in England and the South of France, and has held the posts of Sister at the Radcliffe Infirmary, Oxford, and Assistant Matron of the Downs School, Banstead.

On April 16th, Nurse Cook left the Hospital on completion of her three years' training, and Probationer Jones was appointed to succeed her as Head Nurse in Luke Ward.

On April 28th, Nurse Lumholtz, Head Nurse in Addison Ward, left the Hospital on completion of her three years' training. Nurse Tyson, Head Nurse in Victoria Ward, was transferred to Addison, and Probationer Strappini was appointed Head Nurse in Victoria.

On May 19th, Nurse Blair left the Hospital on completion of her three years' training, and Probationer Fanconi was appointed to succeed her as Head Nurse in the Out-patient Department.

On May 25th, Nurse Leigh left the Hospital on completion of her three years' training, and Probationer Mullan was appointed to succeed her as Head Nurse in Luke Ward.

On May 25th, Probationer Shrewsbury was appointed Head Nurse in the Eye Wards.

The following candidates from Guy's Institution were successful in the recent C.M.B. examination:—A. Clifton, M. A. D. Collingwood, M. Hogg, M. C. Levis, M. K. Tyson, M. H. R. Watkins.

THE EDITOR will, at all times, be glad to consider articles or sketches, provided that they are accompanied by the writer's name and address, not necessarily for publication. Payment is a matter of arrangement, and the fees that the GAZETTE *can offer are merely nominal, but if the writer desires any remuneration that fact should be stated. Authors who desire reprints of their papers should make their own arrangements with the printers when they return their proofs.*

Osteo-arthritis, Tubercle, and the X-rays.

THE well-advised worker in the X-ray field will attribute his successes as well as his failures to the always impersonal X-ray, and shift his responsibilities by the use of such expressions as "the X-rays show," or "he was radiographed." Perhaps in years to come the operator may emerge from the eclipse of his complicated machinery, and we shall hear instead Mr. So-and-so gave such and such an opinion after examining the patient with the X-rays, but for the present the matter is always an impersonal one.

Possibly this system might with advantage be extended to other branches of diagnosis. For example, how much pleasanter to say, "I know a cystoscope which found a hairpin in the bladder which subsequent operation proved was not there," * rather than drag in names and personalities.

Lest our good deeds be interred with our bones, it behoves us to enlarge upon them in print, and we can the more easily do this by the time saved us by others who undertake the responsibility of chronicling our defects. The following interesting case is recorded partly for reasons given above, but mainly to show how a careful interpretation of an X-ray examination may oftentimes form the basis of a diagnosis which will stand by itself, unaided and unimpeded by other methods of clinical investigation.

There are several people involved in the following narrative, two at least being very great surgeons, but because all but the patient, Dr. Winslow Hall and myself are villains, they will be cast into the obscurity which can only be effected by the non-inclusion of their names in an article of this description.

Dr. Winslow Hall has most kindly furnished most of the details which I append.

On June 2nd, 1908, I was called to see a patient who was suffering from a swollen knee. Patient, elderly unmarried lady. Family history, markedly tubercular.

October 4th.—Slipped on fallen leaf and fell on her knee.

October 5–7th.—Rest.

October 8–26th.—At work (teaching).

October 26th to November 10th.—Rest and "Bier" treatment.

November 19th to December 16th.—At work wearing bandage. Calmette's test gave positive result.

December 19th.—Seen by Surgeon A.

December 23rd.—Opsonic indices *before* Bier's bandages, 1·03. *After* two hours, 1·29.

1909, February 27th.—Bier's bandages two hours once a week.

March 12th.—Fluctuation in joint.

April 7th.—A. sees patient, advises amputation, but tuberculin to be tried first.

April 9th to May 21st.—Four injections of tuberculin fortnightly.

June 2nd.—X-rays and diagnosis of *osteo-arthritis*.

June 11th.—Opsonic indices *before* Bier's bandages, 1·08. *After*, 1·01.

June 26th.—Another surgeon, hereinafter called "B," advised operation "politeal space full of pus."

June 29th.—Aspirated fluid examined. No pus, no organisms.

Case then seen by another medical man (C), a relation, who agreed in rejecting diagnosis of tubercle and amputation. Treatment by Scott's dressing, and pot. iod. in large doses, then Thomas' knee splint, then crutches. Steady improvement until 1909, when walking on own feet, wearing a poroplastic case round knee, and using stick and a crutch.

July–October.—Away in Ireland; on return amputation demanded by patient, and performed by A.

I make a few extracts from a letter sent me on October 7th, 1909, by Dr. Winslow Hall:—

> "DEAR SIR,
>
> Probably you have not forgotten that knee of Miss ———, which you radiographed for me last summer. The sequel will interest you."

Here follow a few details unimportant to the subject in hand, and Dr. Winslow Hall continues:—

> "When she returned, he (C.) wrote to me strongly urging amputation, on account of her confirmed and increasing invalidism. She herself desired amputation, and her relatives also urged it.
>
> I pointed out that the joint had been steadily improving, and that a useful limb could be counted on in time. I maintained that the limb, as a limb, did not require removal, but that possibly she might require removal from her limb.
>
> A. was asked to see her again. He promptly advised amputation. Accordingly he did a supra-condylar amputation yesterday. *The joint showed*

* An actual case, but not in any way connected with Guy's.

no sign of tubercular disease, but was typically osteo-arthritic, with very thick-growing ligaments and considerable eburnation of cartilage and bone.

If you care to see the specimen, you will find it at X.Y.Z. Hospital. You see you were quite right. Other comment is needless."

Looking back over the history of this case, certain facts stand out vividly. The great surgical opinions, so positive and so wrong; the convincing circumstantial evidence in favour of tubercle; the whole so biasing to the new-comer that it needed much courage and faith to uphold what seemed an impossible theory, the theory of osteo-arthritis as divulged by the X-rays. The instinctive leaning towards this theory of the patient's medical attendant, Dr. Winslow Hall, before and after the X-ray examination.

It would seem suitable in conclusion to point out a few of the important signs given by the X-rays in osteo-arthritis as opposed to those found in a tubercular joint, and at a later date I hope to do this more fully. Being among the first, if not the first, to point out the curious X-ray appearances of rheumatoid and osteo-arthritis to the X-rays (*Clinical Journal*, May 29th, 1901), my attention has been drawn to the subject for many years, and though there is "a look" about an osteo-arthritic joint which to the experienced eye is unmistakable, it is with difficulty that I am able to determine upon facts which will serve as guides to the diagnostician.

In the first place, the characteristic which these two diseases have in common—a thinning of the mineral matter—is, paradoxically, the most important factor in their differentiation.

The thinning of the mineral matter in the bones of tubercular arthritis is of such a general character that perhaps the best simile would be a chalk drawing very much "rubbed out"—a blurred faint image. Hence, a characteristic radiogram of a tubercular joint is a disappointing one from a pictorial standpoint.

"Mr. So-and-so would be glad if you could get him a clearer radiogram of such-and-such a joint" has been said to me so often in relation to tubercle that I am bound to admit my indebtedness to Mr. So-and-so for pointing out an indisputable fact—which he has failed to recognise himself—that the general X-ray characteristic of tubercular joint disease is want of contrast and want of detail.

Turning to rheumatoid and osteo-arthritis (I cannot find any X-ray line of demarcation for these diseases, and so will speak of them as if varieties of the same), a thinning of mineral matter is most noticeable, but of a totally different nature to a tubercular thinning.

Certain portions only of the bone are thinned, and in such a way as to produce an outlined effect not only of the bones, but of their internal structure. I would suggest, as a simile, the skeleton leaf. The result of this special form of absorption of the mineral matter is to increase detail and strengthen the outline of the photographic image. In other words, the radiogram is, from a pictorial aspect, prettier than normal.

To summarise, the tubercular joint gives a radiogram of a disappointing, fluffy and ill-defined appearance, while the osteo-arthritic joint gives a particularly brilliant one. I cannot say that every case will present these characteristics to such a marked degree that no one could err in a diagnosis, but I will confidently affirm that in a greater or lesser degree they are always present. Perhaps a comparison of a typical example of each disease will do more than anything to rivet this fact in the memory.

E. W. H. SHENTON.

Pass List.

Royal College of Surgeons of England.

Final Examination for the Licence in Dental Surgery, May, 1910.

Parts I. & II.

H. Harrison.	A. E. F. Peaty.
E. P. Hudson.	A. G. Poock.
S. W. Ingram.	C. F. Snow.

Part I. only.

H. F. Barge.	G. E. H. H. Phillips.
H. J. Burch.	C. E. Rice.
R. N. Curnow.	G. E. Rowstron.
F. S. Glover.	A. T. Rycroft.
W. J. Kennealy.	W. A. Thompson.
E. A. C. Knox-Davies.	W. H. Wotton.
S. Lawson.	E. O. Yerbury.
C. H. G. Penny.	

Part II. only.

G. V. Dymott.	H. S. Morris.
N. Edgar.	A. J. Reynolds.
H. H. Glover.	C. F. L. Ruck.
K. G. Hoby.	A. J. Schaefer.
F. A. Lowe.	H. Sturton.

First Examination for the Fellowship.

G. E. Genge-Andrews.	J. F. G. Richards.
G. S. Miller.	W. Robinson.
C. H. G. Pochin.	D. Wilberforce Smith.
A. J. Hull.	

Tubercular Hip. Showing disappointing appearance of radiogram in this disease.

Osteo-arthritis. Showing thinning and outlining of bones.

Osteo-arthritis, Tubercle, and the X-rays.

Alcohol and the Organism.

Paper read before the Guy's Physiological Society by Mr. J. A. RYLE.

MR. CHAIRMAN AND GENTLEMEN,—In approaching a subject of such wide extent and so varied in its points of view, a few words of an introductory nature may not, I think, be considered out of place.

I have divided my paper primarily into two parts, the first of which deals with the effects of alcohol on living organisms from the physiological aspect, while the second deals in a general way with the influences of the use of alcohol on the social organism, and with alcoholism as a factor in racial degeneration. With much of the first part you will no doubt be already familiar, but I have not considered it advisable to omit it for that reason, seeing that without it my paper would necessarily appear incomplete.

It would be obviously impossible, in a discussion of this kind, to keep strictly within the limits of pure physiology, and I must therefore ask you to bear with me in those instances in which I have found it necessary to make incursions into the realms of other but allied sciences.

PART I.—ALCOHOL AND LIVING ORGANISMS.

Dealing, firstly, with the effects of alcohol on living protoplasm in its simplest forms, we are able to draw striking conclusions with regard to its toxic actions. Many experiments have been made on the lower forms both of animal and vegetable protoplasm, and the results in every case point to the fact that alcohol, even in minute quantities, is a strong protoplasmic poison.

Experiments on the growth of the yeast plant (Torula) have shown that a solution of ethyl alcohol of only ·001 per cent. is sufficient to almost halve the rate of cell division. The stronger the solution the more potent is the effect, and it is a well-known fact that the organisms are killed outright if the concentration reaches 13 or 14 per cent.

With the seeds of cress it has been shown that 1 per cent. alcohol solutions are capable of inhibiting germination, and in the case of the cress plant of diminishing the rate of growth and seriously impairing the production of chlorophyll.

Amœbæ appear to be able to exist in solutions of as much as 5 per cent. of alcohol, but in every case, and even in much weaker solutions, they are affected with a more or less complete inhibition of normal movement.

The ova of the blow-fly and the ova of the frog do not mature as quickly as they should normally when subjected to an alcoholic medium, and even the development of hens' eggs is considerably delayed and disorganised by the action of quite small quantities of alcohol, present either as vapour or in watery solution, though perhaps this may be partly due to a blocking of the respiratory exchanges.

These instances are, I think, sufficient to demonstrate the effects of alcohol on the simpler organisms. The question naturally becomes more complicated when we have to deal with the higher animals, but the scientific value of the inquiries becomes at the same time more apparent.

As the actions of alcohol are essentially similar in the higher animals and man, and as it has been possible to carry out on man most of the experiments required for demonstrating the physiological or pharmacological actions of alcohol, we can proceed directly to a consideration of the influences of alcohol on the human body.

Careful distinction must of course be drawn between the effects of alcohol and of alcoholism, and for that reason I have kept considerations of the two as far as possible separate from one another.

THE EFFECTS OF ALCOHOL ON THE HUMAN ORGANISM.

It will be necessary here to consider severally the actions of alcohol on the different organs and functions of the body, and it may be as well to discuss, first, its actions on those parts with which it first comes in contact, when administered internally.

Direct contact of alcohol with the mouth produces a slight reflex salivary secretion, which is characterized by its greater digestive power over farinaceous food than is ordinary saliva. Alcohol augments the flow of gastric secretions mainly by its direct action on the gastric mucous membrane, but partly as the result of its absorption into the blood-stream. It is, however, noteworthy that alcohol only augments the flow, and does not necessarily induce the cells to secrete an active ferment. Alcohol is very rapidly absorbed from the stomach, and on this fact depends its use as a restorative. In the case of a dog with a ligatured pylorus, as much as 200 cc. of a 37 per cent. solution was absorbed during a period of three hours.

The passage of alcohol out of the stomach is accompanied by a flow of water into the stomach; the endosmotic equivalent being 4·13. In small quantities alcohol is said to slightly accelerate proteid digestion. Peristalsis is very considerably increased by its administration. If, however, alcohol is given in intoxicating doses, it seriously interferes with digestion, owing to the general nervous and vascular depression which results. Turning to a consideration of the effects of alcohol on the circulation, the resulting changes in pulse-rate can be accounted for in two ways. In the first place, it must be remembered that excitement of any sort is apt to increase the pulse-rate, and alcohol is well known to be an exciting agent of no inconsiderable potency. In the second place, a rise in pulse-rate can be brought about by peripheral irritation, that is of the gastric mucous membrane. It is found that small doses administered to a non-addicted subject quicken, whereas large doses, owing to their action on the medulla, diminish the pulse-rate. In regard to the heart, alcohol can be said to have a small but definite stimulant action, which is

put down to the fact that alcohol is an extremely easily assimilable source of energy. Alcohol causes dilatation of peripheral vessels, and at first tends to constrict the systemic vessels. Blood-pressure is usually raised by its administration, but general vascular depression usually results from taking it in large quantities.

With regard to respiration, Binz pointed out that alcoholic beverages have a stimulatory action. Jaquet agreed with him, but declared it to be due to gastric irritation, and not to any influence on the medulla. It is more probable, however, that the increased heat-loss, due to consumption of alcohol, calls for a compensatory oxygen increase, and this would be sufficient to account for augmented respirations.

Much work has been done in the way of investigations into the effects of alcohol on muscle, and the general conclusion seems to be that alcohol causes a slight increase in muscular work, but that that increase is very short lasting. Experiments were made on soldiers on the march, and it was found that the administration of alcohol was of no value except for the first few minutes. The probable explanation of its supposed value as a muscular stimulant is that it lessens fatigue owing to its action on nerve-endings. It must be obvious that its use as an alleviator of fatigue is in reality a dangerous proceeding, in so far as fatigue is the natural indication that enough work has been done. The great rise in industrial drinking can be almost entirely attributed to the belief that alcohol causes an increase in muscle energy, whereas its real effect is nothing more than a deadening of sensations.

It is, of course, probable that some slight increase in energy results from the oxidation of alcohol in the tissues, but in the words of Professor Schäfer, "It cannot be doubted that any small production of energy resulting from the oxidation of alcohol is more than counterbalanced by its deleterious influence as a drag upon the tissue elements and especially on those of the nervous system."

This brings me to the discussion of the effects of alcohol on the nervous system, and it is upon this part of the human organism that its influence is most pronounced, and at the same time most complicated and interesting. The general results of a dose of alcohol may be enumerated as follows:—The subject is at first filled with a sense of well-being, later he becomes more and more reflex in his actions. He loses his self-control and exhibits an excess of motor energy, which is characterized by the lack of dignity displayed in every movement. With larger amounts a paralytic stage ensues, followed by coma, and eventually death from respiratory failure.

When given in small doses alcohol quickens the reaction of the subject and renders differences in the weights of objects more easily recognisable; a period of depression usually follows.

Dr. Aschaffenberg made some careful and interesting experiments on the work of compositors, work which involves rapid thought and accurate muscle response. He found that small quantities of alcohol diminished the output and quality of the work done, as compared with that accomplished on days on which the subjects abstained. The men, however, were under the impression that they were doing better than usual. It should be mentioned that of the subjects chosen three were moderate drinkers, and one was known to drink to excess occasionally.

The effects of alcohol on the nervous system are explained in two ways. According to Binz's theory, alcohol first stimulates and then depresses the central nervous system. Schmiedeberg, however, maintains that there is no stimulation, but depression from the very beginning—the alcohol acting on those centres first which were developed last. It is in this way that the finer degrees of sensibility are the first to go, and that the medulla is affected last of all. Any stimulatory results are, by this theory, put down to depression of inhibitory centres.

The balance of evidence is in favour of Schmiedeberg's view, and it certainly seems the more probable of the two.

Little need be said with regard to the influence of alcohol on body-temperature. The production of heat seems to remain almost unchanged with small doses, and it is well known that alcohol causes a great loss of heat from the surface of the body, a loss which is attributable to the extensive vaso-dilatation produced.

ALCOHOL AND METABOLISM.

Proceeding to the discussion of alcohol and general metabolism, we are at once confronted with the much-vexed question as to whether alcohol can be definitely described as a food or not, and definitions of a food obviously become necessary. I have chosen the two following.

A food may be defined as—(1) "Any substance which, when absorbed into the blood, will nourish, repair waste, and furnish force and heat to the body without causing injury to any of its parts or loss of functional activity." (Alcohol and the Human Body.—Horsley and Sturge.)

(2) "As a substance absolutely necessary to the normal composition of the body, or as a substance which can be acted upon by the tissues of the body in such a way as to yield energy or to furnish material for the production of living tissue." (Howell's Physiology.)

It will be seen that alcohol cannot be said to conform accurately to these definitions. In the first place, if used as a food, or if taken regularly in large quantities, it does cause "injury and loss of functional activity," and in the second place it cannot be described as "a substance absolutely necessary to the normal composition of the body."

Many people maintain that it is a food merely because it is oxidised in the tissues; but it should be pointed out that morphia and phosphorus, which are admittedly poisons, are both oxidised to a certain extent in the body. The popular belief that alcohol acts like a food is of course due to the fact *that it allays sensations of hunger*,

a phenomenon which is obviously the result of its action on the nervous system.

Alcohol differs greatly from most food-stuffs in that it enters the blood-stream unchanged. In moderate doses it is almost entirely oxidised, and must for that reason yield a certain amount of energy. Atwater and Benedict showed that, when 2½ ounces of alcohol were given daily to a man, the proportion excreted in the urine unchanged never reached more than 2 per cent., and as no intermediate products are known to exist, it is presumably converted straight away into CO_2 and water.

Atwater and Benedict are also responsible for experiments on the fat-sparing properties of alcohol. They showed that if 2½ ounces of alcohol be made to replace fat of an equivalent calorific value from a fixed diet, the same amount of energy is utilized as before, and roughly the same heat given off. The alcohol is known to be oxidised, and, since no extra heat is given out, it must be usefully consumed, or, in other words, it succeeds in sparing fat. The fatty degeneration observed in alcoholics is very probably due to this property of alcohol, and it certainly does not follow that alcohol is as good a source of energy as fat, the rapidity of its combustion and the resulting heat-loss counterbalancing the beneficial effects. The question as to whether alcohol can act as a protein-sparer is somewhat more complicated.

If all carbohydrates are withdrawn from the diet of a man in nitrogenous equilibrium, an increased loss of nitrogen is immediate. The loss due to removal of carbohydrate may be made good by administering fat, but alcohol does not have the same effect. Further, if a man is in nitrogenous equilibrium on a fixed diet, the addition of alcohol causes an increased output of nitrogen, and, therefore, although it may be said to supply energy, alcohol also exerts a toxic effect. It is found, however, that after prolonged use the toxic effect is lost, owing to resulting tolerance, and alcohol may then be even described as a protein-sparer.

On the above grounds Dixon concludes that alcohol is a food if taken in moderate quantities. In excessive amounts it is admittedly toxic. "It is," he says, "a food in so far as it is oxidised in the body; it is a poison to the tissues when an amount is present in the system greater than can be dealt with at the time."

In any case it must be apparent that alcohol is a most undesirable food from the economic point of view, while from the physiological point of view it must also be obvious that it is not, and could not conveniently be taken in such scientifically accurate quantities as to render the name of "food" justly applicable. Finally, in regard to all the physiological actions of alcohol, allowances must always be made for personal idiosyncrasies and the mode of life of the individual.

I now wish to deal shortly with some more recent and exceedingly interesting investigations which have been made in regard to alcohol and immunity. This branch of the study of alcohol in connection with the human organism, as an account of the results already obtained will testify, promises to be one of the utmost importance. Delearde's attention was first attracted to the subject by some observations which he was enabled to make upon two patients who were both bitten on the same day by the same mad dog. Both were treated carefully and completely with antirabic treatment. The one, a man of 30, who had only been bitten on the hand, died, while the other, a child of 13, who had been bitten on the head and face, recovered. The only explanation that could be found to account for the death of the man was the fact that he was known to have been intemperate.

This prompted Delearde to carry out experiments on rabbits. He first vaccinated several of them against hydrophobia, and was entirely successful. To some of these he administered 1½ to 2¾ teaspoonfuls of alcohol daily, with the result that no immunity was produced. When alcohol was given before the vaccination period and discontinued during it, he found that a certain degree only of immunity resulted. Similar experiments have also been made in regard to cholera, tetanus, anthrax, and tuberculosis, with similar results.

Much more thorough and exhaustive work has been done on this subject recently by Professor Laitenen of Finland, and whereas formerly we were only possessed of clinical evidence in regard to the fact that the resistance of human subjects to disease was seriously impaired by alcoholic tendencies, we have now a very complete collection of scientific data to the same effect. Professor Laitenen has carried out extensive investigations on human subjects, employing opsonic index methods, and he has brought forward evidence to show that even small doses of alcohol weaken the normal resisting power of the body. In his earlier experiments, performed on animals, he showed that the resistive power of red-blood corpuscles tested against a heterogeneous serum was diminished by alcohol even in small quantities. More recently he has endeavoured to determine the comparative hæmolytic power of blood-serum in alcohol-drinking and abstinent subjects. "He examined blood from 223 persons of all classes and ages, and as the result of his observations he concludes that by the consumption of alcohol the normal resistance of human blood-corpuscles appears to be somewhat diminished against a heterogeneous normal serum or an immune serum, provided that tolerably large equal, or nearly equal, number of drinkers and abstainers of both sexes be examined." (*Med. Temp. Review.*) He also showed that the bactericidal power of blood-serum against typhoid bacteria was less in the case of drinkers than abstainers, and the term "drinker," it should be noted, he uses as implying anyone who has taken alcohol in any quantity whatever. The statistics and tables, which have been drawn up with a view to illustrating his conclusions, I have omitted as being too complicated and extensive for reproduction here. They were published in the *British Journal of Inebriety* for October, 1909.

Some further interesting facts have been recently brought to light in regard to alcoholism and plumbism, an interesting account of his experiences and conclusions being given by Dr. Hill (certifying factory surgeon in

the Staffordshire pottery district) in the *British Journal of Inebriety* for January, 1910.

The symptoms resulting from lead-poisoning are terrible and disabling in the extreme. The chief mode of entry of the poison appears to be by inhalation, but the workers ascribe a great proportion of their sufferings to absorption by the skin. As the work they have to do is exceedingly arduous, and carried out frequently at enormously high temperatures, it is not surprising that beer is partaken of in abundance, and further, the general impression among the lead-workers is that beer is a specific against lead-poisoning.

I quote an instance given of a typical case: S. W., aged 32, ground layer, severe colic, double wrist-drop and slight albuminuria. "Has been freely drinking for a twelvemonth as a cure for the lead."

It seems to be the unanimous opinion of certifying surgeons in the district that alcohol plays a most important part in the causation and maintenance of plumbism, and Sir T. Oliver, in his "Diseases of Occupation," says, "There is not the least doubt that alcoholic intemperance predisposes to lead-poisoning." The same authority made experiments on rabbits, and found that these animals became more rapidly poisoned when dosed with a mixture of alcohol and lead than when fed on lead compounds alone. Similar results were obtained with cats and dogs, which are extremely susceptible to lead-poisoning. Dr. Hill supposes that "alcohol, by checking elimination, or perhaps by reprecipitating soluble chlorides, must tend to induce deposits of lead in the tissues." He also points out that the symptoms of alcoholism and plumbism are very similar, and that resulting post-mortem conditions are difficult to distinguish. The most important statement, however, in the whole of Dr. Hill's paper is to the effect that plumbism is practically non-existent among total abstainers. He even instances cases of alcoholic subjects suffering from lead-poisoning, who were induced to try the effects of abstinence, and who subsequently lost all the most serious symptoms of the disease, such as tremors, wrist-drop, and anæmia.

The various conclusions which I have cited above will, I think, be sufficient to indicate how extensive and serious the influences of alcohol can be, especially in regard to the manner in which they seem capable of reducing the resistance of the body-tissues to various forms of infection and disease. It is possible that some of the effects may be in part cumulative, but Laitenen's experiments and other investigations all point to the fact that much of the evil is actually due to lessened resistance.

I quote below from two tables, which occur in Horsley and Sturge's "Alcohol and the Human Body"; the first includes diseases or pathological conditions directly attributable to alcoholism, the second conditions of which alcoholic habits are frequently a determining or contributing cause:—

TABLE I.	TABLE II.
Acute Alcoholic Poisoning.	Pharyngitis.
Delirium Tremens.	Gastric Catarrh.
Chronic Alcoholic Insanity.	Cirrhosis of Liver.
	Obesity.
	Arterio-sclerosis.
	Functional disorders of Ovaries and Breasts, resulting in sterility and inability to suckle.
	Epilepsy.
	Melancholia.
	Hysteria.
	Imbecility.

It will be noticed that the nervous system claims a very large share of the disorders resulting from, or partially attributable to alcoholism. This is entirely in accordance with the scientific results obtained in regard to the pharmacological actions of alcohol, which are more pronounced on the nervous system than on any other part of the human organism. Furthermore, these observations go a long way towards contradicting the objections made to the effect that the ills resulting from alcoholic excess are due more to the other alcohols and impurities present in alcoholic beverages than to the presence of ethyl alcohol itself, since lesions would be expected to result from the constant use of a drug possessed of such decided actions. I do not for a moment deny that the impurities in a large proportion of the liquors sold must add to the toxicity of those liquors, and it is probable that if a law in regard to the adulteration of alcoholic beverages, as rigorous as that which applies to the adulteration of foodstuffs and milk, were introduced, it would not be long before the results of such legislation became apparent.

The second part of my paper, which deals with alcohol, or, more correctly speaking, alcoholism and the race, embraces an aspect of the problem which must obviously be of great interest both to the medical man and the sociologist. My only regret is that I have been unable to obtain more facts and evidence on the subject, and that my paper is consequently of less interest and value than it might otherwise have been.

PART II.—ALCOHOLISM AND THE SOCIAL ORGANISM.

A proper study of the children of a race is obviously one of the first essentials in the science of Sociology, and for that reason I cannot, I think, do better than begin this section of my paper with some considerations of the effects and consequences of parental alcoholism. These can, in the first instance, be divided into two classes—(1) the direct, and (2) the indirect effects. I will not dwell at length on the indirect effects of parental alcoholism, as they are unfortunately only too obvious. The expenditure on drink of money which might have been saved or spent on food and clothing for the family is one of the primary evils, and one which reflects most severely on the children of the poorer classes. Almost more serious results, however, accrue from the general squalor and inattention which so

frequently characterise the home of the alcoholic. Clearly the moral and physical surroundings in such homes are most unfavourable for the production of a healthy progeny.

Deaths from overlaying are, in a large number of cases, the result of alcoholic excess on the part of the mother.

Dr. Templeman states:—"There can be no doubt, too, that drunkenness on the part of parents is a very important factor in the production of our infant mortality. Apart from the effects of this on the child *in utero*, there is another aspect to which I would allude, viz., deaths from overlaying. These cases occur, as a rule, in one and two-roomed houses, and in a large majority of cases in families in which the parents are of dissipated and dissolute habits, and living amidst squalor and filth. Of 461 cases which have come under my own observations as surgeon of police during the past 20 years, no fewer than 219, or 47 per cent., occurred between Saturday night and Sunday morning, a fact which speaks for itself."

In turning our attention to the direct effects of parental alcoholism we have both pre-natal and post-natal influences to consider, and in regard to the former we find that the inheritance of serious defects as the result of alcoholic habits in the parents is something more than common. These defects may be due to alcoholism in either or both of the parents. Only a small number of drinkers' children are quite normal—17·5 per cent. according to Legrain, 6·4 according to Demme, and 11·7 according to Demoor; so that though these figures are probably too low, at any rate the proportion does not appear to be a high one.

Alcoholism in the mother is characterised by various undesirable results. Children are either born malformed, or else they are still-born or non-viable. Dr. Sullivan, in a personal investigation carried out some years ago, ascertained that of 600 children born of 120 drunken mothers, 335 died in infancy or were still-born, and that several of the survivors were mentally defective, and as many as 4·1 per cent. were epileptic. Parental alcoholism seems to result especially in abnormalities of the nervous systems of the offspring. "Many children of alcoholic parentage show signs of stupidity, mental deficiency, moral instability, and lack of normal control, whilst others exhibit idiocy, epilepsy and hysteria, together with various unbalanced cravings." In support of his views in regard to parental alcoholism as a factor in the causation of nervous defects, Professor Hodge has carried out some interesting experiments, with rather striking results. Two dogs were given alcohol with their food. Twenty-four puppies were born in four consecutive litters, and of these twenty-four only four proved viable; whereas out of 45 puppies born in eight consecutive litters from normal dogs, 41 were viable and vigorous. Examinations of the brains of the non-viable pups showed no traces of medullation, whereas normal pups, killed at birth, were found to possess medullated fibres in the sensori-motor areas. Professor Demme obtained strikingly similar results from observations on alcoholic and non-alcoholic human families.

Professor Demme's Observations.

	10 Alcoholic Families.	10 Normal Families.
Number of children	57	61
Deformed ...	10	2
Idiotic	6	0
Epileptic, choreic	6	0 (2 backward)
Non-viable ...	25	3
Normal	10=17 per cent.	54=88·5

(From "Alcohol and the Human Body."—Horsley and Sturge.)

No entirely definite statement can be made as to how far the tendency to inebriety is inherited. We can only declare this to be the case in so far as we can declare that nervous defects and faulty organisations are transmissible and transmitted, and that consequent lack of will-power must in many cases lead to alcoholism in the children of alcoholic parents.

Of the post-natal direct consequences of parental alcoholism, there is only one with which I intend to deal here. It is one which must play a very large part in aggravating that decline of the birth-rate which has given rise to so much discussion and anxiety in the past few years, and which is in many countries becoming a really serious menace. I refer to *deficient lactation*, which appears to be one of the most common results of alcoholic habits, and which is, moreover, transmissible.

It is well known nowadays that an enormous percentage of infantile deaths occur during the first few months after birth. These deaths are to a great extent due to the fact that the children do not receive a proper amount of their mother's milk, and this is frequently owing to the fact that the women are actually incapable of suckling their infants for the normal period. So important and serious did these deficiencies in maternal functions appear, that Professor Bunge determined to carry out a series of researches and investigations of a scientific nature in the hope of finding a cause to account for the phenomenon. He seems to have been very successful, and I quote from his own report. He begins:—"The question may be put, Why do women not effectively suckle their infants? Some put forward the difficulty of so doing; others are prompted to it by bad husbands. But these only form a very small minority. The number is greater of those women whom professional occupations keep from lactation. But these also form a minority. The majority of women who do not suckle their infants is composed of those who cannot, physically speaking, do so. The quantity of milk is not sufficient; artificial feeding must be superadded, and, at the end of some weeks or months, the source of the milk is completely dried up. This inability to suckle is in constant increase. In the towns of Germany and Switzerland more than half of the women are already attacked by this inability." (By "inability" he means inability to suckle for nine months.)

"I have made it my task," he continues, "to find out the causes of this inability by means of statistical

procedures. I first of all found it to be hereditary. When a woman is unable to suckle, it is almost without any exception that her daughter cannot do so, and the power appears to be lost for all the next generation. . . . There are some cases, and these are not rare, where the mother having been able to suckle, the daughter has not been able to do so. Here we are close to the causes of the incapacity, and shall find it in the father, and we at once encounter alcoholism. In 78 per cent. of these cases, in my statistics, the father is an immoderate drinker. On the other hand, in the families where the mothers and daughters can suckle their infants, drunkenness is rare. . . . The rule is that if the father is a drunkard, the daughter loses her power of suckling."

These results of Professor Bunge's are striking in the extreme, and it is to be hoped that still further investigations will be shortly made in the same direction with a view to obtaining the fresh evidence which a subject of such importance demands. Having given you some idea as to the part played by alcoholism in causing an increased infantile mortality, and in producing degenerate types, I will now, before bringing my paper to a close, consider shortly the connections of alcoholism with suicide and crime.

ALCOHOLISM AND SUICIDE.

It is extremely difficult to obtain statistics correlating alcoholism and suicide, and such statistics can never be entirely reliable, but it is possible by utilising police and other official returns to show a definite connection between the two. We are able, for instance, to discover in what trades and employments the proportion of suicides is highest, and we generally find that alcoholism is a feature of these trades, prominent among which are those of the publican, the cab-driver, the commercial traveller, and the hair-dresser. Further, the ages at which suicidal tendencies appear are of great assistance, the alcoholic type being prevalent in the earlier years of life, and the type of suicide due to other causes predominating with the approach of senility.

These two points are well indicated by the following figures from the Registrar-General's returns, which show how suicides are most frequent among alcoholic classes, and at ages below forty-five, while the less alcoholic class has a lower rate and a different age-incidence.

SUICIDE RATES PER MILLION.

Ages	25	35	45	55	65
Alcoholics ...	181·9	188·6	131·7	147·4	157·2
Publicans ...	260·3	246·8	166·9	156·2	100·9
Agriculturists	64·2	68·8	70·6	78·1	86·6

There does not appear to be a very close connection between alcoholism and certified insanity, but in regard to crime we can assert that alcoholism is a factor in the causation of a large proportion of the more violent types.

Homicidal offences, and, to a less extent, crimes of lust, can be attributed to a certain extent to the influences of alcoholism, whereas crimes such as those of acquisitiveness are naturally influenced to an insignificant degree.

Here, again, we find that it is usually the chronic type of alcoholism which is responsible for the resulting evils; for though drunkenness may promote impulses of acquisitiveness and sexual impulses, chronic intoxication seems to predispose to homicidal and suicidal impulses, and sexual impulses of an aberrant sort.

It is somewhat surprising to find that crimes of violence have tended to decrease, in spite of the continuance of a high rate of alcoholism. This is, to a great extent, accounted for by the general noticeable trend of manners to conduct of a less rude and aggressive type, and the substitution for violent acts of fraudulent and deceitful methods.

In summarising the conclusions which I have been able to draw, I can only say the work of scientists and of sociologists, together with the observations of the medical profession, all point to the fact that alcoholism, and especially parential alcoholism, plays an extremely significant part in the production of such undesirable members of society as idiots, epileptics, prostitutes, feeble-minded criminals, and, in short, of most constituents of the abnormal classes, and that it can for this reason be definitely set down as one of the most potent factors in the causation of racial degeneracy.

The Physical Degeneration Committee for 1904 expressed its opinions as follows: "As the result of the evidence laid before them, the Committee are convinced that the abuse of alcoholic stimulants is a most potent and deadly agent of physical deterioration." It is not often that a Departmental Committee expresses its sentiments with such vehemence as this.

I have not attempted to discuss the causes or the cure of industrial drinking, and I have not attempted to deal with the question of legislation in regard to alcoholism, as I considered that both of these were outside the sphere of my paper. In conclusion, I will only say this, that the waste of life and of health, and the waste of money, both by direct expenditure, and by State expenditure for the maintenance of prisons and asylums, and for purposes of criminal administration, are all in part attributable to the prevalence of alcoholism. The country which fosters any one cause of such evils is fostering a pathological condition. Our aim should be to restore it to a state of physiological equilibrium.

Sport.

Cricket.

GUY'S v. SEVENOAKS.

Played at Sevenoaks on May 14th. The visitors won the toss, and went in to bat on a soft wicket. They were dismissed for 57 runs, Montgomery taking three wickets for 10 runs, Rhys Evans three for 18, and Harkness three for 28. The runs were knocked off for the loss of four wickets, Guy's eventually reaching the total of 160.

SEVENOAKS.

J. C. Richardson, c & b Harkness	6
J. D. Adamson, c & b Harkness	12
C. W. Denning, c Hunôt, b Evans	0
H. T. Cross, b Harkness	0
G. Steer, c Hunôt, b Evans	2
A. W. Martin, c Messinier, b Evans	1
F. Mills, c Evans, b Montgomery	4
E. J. Blackmore, run out	17
G. M. Measures, b Montgomery	5
E. Francis, C. Dinan, b Montgomery	5
T. Sills, not out	4
Extras	1
Total	57

GUY'S.

M. M. Munden, c Adamson, b Mills	37
G. Dinan, run out	8
E. S. Bowes, lbw, b Denning	4
A. F. Rook, b Denning	4
A. H. Birks, c Denning, b Sills	0
F. C. Hunôt, b Adamson	29
R. Montgomery, b Francis	32
A. H. Harkness, c & b Francis	0
G. Messinier, run out	19
J. E. Rhys Evans, c sub., b Francis	5
G. Housden, not out	0
Extras	22
Total	160

GUY'S v. CROFTON PARK.

Played at Honor Oak Park on May 16. The visitors, having scored 122 for the loss of only two wickets, were eventually dismissed for 189, A. F. Rook taking seven wickets for 39 runs. Guy's knocked off the runs for the loss of four wickets, eventually reaching the total of 249. Munden, after an uneasy opening, hit brilliantly, giving no chances in his century. Blackwood played a steady and very valuable innings of 71.

CROFTON PARK.

Theobalds, b Rook	51
Partridge, b Dinan	22
Knight, b Rook	51
Brierly, b Rook	5
Hone, b Rook	13
Cotton, lbw, b Rook	3
Murrell, b Rook	7
Day, c Bowes, b Montgomery	7
Barr, c Harkness, b Montgomery	7
Whittaker, not out	2
Mansell, b Rook	2
Extras	19
Total	189

GUY'S.

M. M. Munden, c Brierly, b Barr	107
G. Dinan, b Day	1
A. F. Rook, b Barr	10
A. H. Birks, b Barr	12
B. Blackwood, b Brierly	71
R. Montgomery, c Mansell, b Barr	11
F. C. Hunôt, c Brierly, b Day	7
C. H. Medlock, c Murrell, b Day	11
E. S. Bowes, not out	1
A. H. Harkness, c Mansell, b Brierly	0
J. E. Rhys Evans, absent	0
Extras	18
Total	249

GUY'S v. HAMPSTEAD.

Played at Honor Oak Park on May 18th. Guy's won the toss, and batted first. Montgomery and Munden made a good beginning, making 62 before the latter got out. After this the wickets fell quickly, and Guy's were all out for 142. Hampstead were dismissed for 91, Rhys Evans taking five wickets for 18 runs.

GUY'S.

M. M. Munden, c Huckstep, b Everitt	17
R. Montgomery, c Hatchley, b Tanner	59
B. Blackwood, b Everitt	5
A. F. Rook, b Horne	2
G. Dinan, lbw, b Horne	0
A. H. Birks, b Huckstep	15
F. C. Hunôt, b Tanner	3
B. F. Sampson, b Everitt	14
R. S. Kennedy, b Everitt	3
E. S. Bowes, not out	2
J. E. Rhys Evans, c Huckstep, b Tanner	3
Extras	19
Total	142

HAMPSTEAD.

A. R. Tanner, c Bowes, b Rook	7
J. D. Donaldson, b Evans	48
A, S. Everitt, lbw, b Rook	0
H. S. Horne, lbw, b Sampson	9
W. E. Pollock, lbw, b Evans	5
W. S. Hale, lbw, b Evans	7
S. Monilaws, b Blackwood	0
W. A. Evill, not out	7
A. W. Hatchley, run out	2
Huckstep, b Evans	2
F. Atkins, b Evans	0
Extras	4
Total	91

GUY'S v. REIGATE PRIORY.

Played at Reigate on May 21st. Guy's won the toss, and went in first on a soft wicket, and, with the exception of Digby, who batted splendidly, gave a very tame display. Unfortunately, Montgomery, the skipper, whose presence was required by the examiners, arrived just too late for his innings. Digby secured four wickets for 18 runs.

GUY'S.

M. M. Munden, b Penfold	0
G. Dinan, b Barrett	12
B. Blackwood, run out	1
A. F. Rook, b Penfold	16
A. H. Birks, b Penfold	0
F. C. Hunôt, b Barrett	3
W. E. S. Digby, not out	58
B. F. Sampson, c Bowyer, b Penfold	10
A. H. Harkness, c Gebhardt, b Thompson	0
J. E. Rhys Evans, b Penfold	6
R. Montgomery, absent	0
Extras	4
Total	110

REIGATE PRIORY.

Dewhurst, c Digby, b Harkness	1
Motion, c Evans, b Digby	49
H. Gebhardt, c Montgomery, b Rook	19
R. F. Penfold, c Digby, b Evans	13
R. G. Thompson, b Digby	0
Rev. C. J. M. Godfrey, b Digby	2
C. E. Roberts, lbw, b Digby	5
W. S. Simmonds, b Munden	24
A. W. Bowyer, c Rook, b Munden	17
W. D. Ruttley, not out	5
Barrett, c Rook, b Blackwood	0
Extras	11
Total	146

Lawn Tennis.

GUY'S 2ND VI. v. MALDEN.

This Surrey County Junior Cup Tie took place at Malden on Saturday, May 21st, when the Hospital were defeated by six matches to three. Rusult:—

R. H. Lucas and H. L. S. Griffiths lost to L. C. Harvey and G. R. Johnson, 4–6, 3–6; beat S. Nuttall and P. James, 6–2, 6–0; beat W. Pfleidesen and J. C. Stalfox, 7–5, 5–6.

L. Price Harris and G. King beat Nuttall and James, 6–4, 6–3; lost to Pfleidesen and Stalfox, 4–6, 3–6; lost to Harvey and Johnson, 5–7, 3–6.

G. Gordon-Reeve and W. J. D. Smythe lost to Pfleidesen and Stalfox, 5–7, 6–2, 4–6; lost to Harvey and Johnson, 4–6, 1–6; lost to Nuttall and James, 5–7, 7–5, 2–6.

GUY'S 2ND VI. v. DOWNING COLLEGE, CAMBRIDGE.

This match was played at Cambridge on Saturday, May 14th, and resulted in a win for Downing by seven matches to six.

GUY'S 1ST VI. v. CAIUS COLLEGE, CAMBRIDGE.

This match was played at Cambridge on Saturday, May 14th, the hospital being defeated easily in the doubles after dividing the singles. We were very pleased to hear that L. A. Graham, the Caius captain, is coming up to Guy's in October, as his services will be very useful to us next season.

Will all men who wish to play in the Handicap Doubles Tournament, similar to last year's, please enter their names on list in Club Smokeroom before Wednesday, June 1st? Entrance fee 5s. each couple.

Golf.

GUY'S v. ST. THOMAS'.

The above match was played in the first round of the Inter-Hospital Competition, on the Norwood Club Links, on Wednesday, May 25th. The result was a win for Guy's by five matches to four. This entitles Guy's to meet the London or Bart.'s in the final.

ST. THOMAS'.

G. H. Hoffman (5 & 4)	1
F. T. Howarth (6 & 4)	1
W. D. Ross (3 & 1)	1
F. G. Verdon (1 up)	1
C. Bowring	0
L. Meakin	0
W. Shipton	0
R. N. Fry	0
A. L. Hargreaves	0
	4

GUY'S.

L. Bramley	0
W. S. Kidd	0
J. M. Jarvie	0
F. D. Saner	0
R. Curle (4 & 3)	1
J. G. Saner (6 & 4)	1
G. H. Hunt (7 & 5)	1
R. Creasy (2 & 1)	1
W. T. Clarke (5 & 4)	1
	5

Guy's Hospital Rifle Association.

ARMITAGE INTER-HOSPITAL CUP.

The first practice shoot took place on Wednesday, May 24th. Scores:—

E. O. Yerbury	88
H. Hogben	84
G. A. Blake (Captain)	73
L. D. Wright	72
H. J. Leviseur	48
E. A. Leviseur	48
Total	413

E. O. YERBURY, *Hon. Sec.*

Birth.

ALCOCK.—On the 18th May, at Abbey Gate, St. Catherine's, Lincoln, to Dr. and Mrs. Frank Alcock, a daughter.

Marriage.

IRELAND—MILLS.—On 6th April, at St. Thomas Beau Bassin, by the R. R. the Bishop of Mauritius and the Rev. H. H. Buswell, George Hugh Ireland to Jane Mills.

Death.

HITCHINS.—On May 8th, at Trevarrick, St. Austell, Cornwall, Frederick Charles Hitchins, F.R.C.S. Edin., M.R.C.S. Eng., L.R.C.P. Lond., aged 38 years.

Ed.—A. N. C.

GUY'S HOSPITAL GAZETTE.

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Calendar of Coming Events and Ensuing Take-in Weeks.

June.

Sat. 11. Cricket—1st XI. v. The Past (Home).
Tennis—1st VI. v. Balliol College, Oxford (away).
2nd VI. v. Hertford College, Oxford (away).

Mon. 13. Clinical lecture by Mr. Steward (Laryngology), 1.15 p.m.
Cambridge 1st and 2nd, and part I. of the 3rd Examination for M.B. degree begin.

Thur. 16. Messrs. Symonds and Steward's Take-in (Messrs. Evans and Bromley).

Sat. 18. Cricket—1st XI v. Granville, Lee (Away).
2nd XI. v. Manor House School (Home).
Tennis—1st VI. v. Kent (home).
2nd VI. v. St. Mary's Hospital (away).

Mon. 20. Clinical lecture by Dr. Iredell (Actinotherapeutics), 1.15 p.m.

Thur. 23. Messrs. Lane and Fagge's Take-in (Messrs. Mullins and Webster).

Passim.

AS a result of the recent examination for the Beaney Prize in Pathology, the prize has been divided between Messrs. J. G. Saner and A. H. Todd, and Mr. G. Dunderdale has been awarded a certificate.

A VERY interesting book which has recently been presented to the Wills Library by the author, Dr. Albert Churchward, who is an old Guy's man, is "The Signs and Symbols of Primordial Man." A sub-title explains that the work is an "explanation of the evolution of religious doctrines from the Eschatology of the Ancient Egyptians." In spite of its somewhat awe-inspiring titles, the book will be found to contain great stores of interesting information on such subjects as totemism, the habits and spiritual development of such primitive peoples as the pygmies from the forests of Ituri and the Ainus who are attracting so much attention at the Japanese Exhibition, the mythology of ancient Egypt, and the origins of the ritual of Freemasonry. Dr. Churchward, who has previously written a book on "The Origin and Antiquity of Freemasonry," writes from the standpoint of an enthusiastic Freemason. In that cult he sees an agent for the ultimate regeneration of the world; moreover, he believes that when these islands have become cold and buried under ice in a future glacial epoch, the centre of learning and knowledge will return to Egypt, whence it was derived in mankind's infancy, and in illustration he points to the fact that Lord Kitchener, a Freemason, began the building of the University at Khartoum, and that "Britain's sons are now forming a great kingdom from the Cape to Cairo." This is certainly a new side-light with which to view

the recent much-discussed utterance of a certain ex-President at the Guildhall.

THERE is so much—too much—talked and written for and against Socialism in these days that we do not wish often to see a paper called *Liberty*, which is the organ of the Anti-Socialist Union of Great Britain. The current number of this propagandist periodical has, however, been forwarded to us, with a marked article on "Socialism and the Medical Profession." Quoting from this article, it is stated that "In the Red Catechism," compiled for the use of children attending the Socialist Sunday Schools, one of the "lessons" deals with the hospitals. In the form of question and answer, it is stated that "poor people have objections to the hospitals because they are afraid that the students and doctors will make experiments on them, and that the experiments are made in order that the doctors may obtain experience which they can sell to the rich, as the latter would not tolerate students practising upon them. This is one of the unscrupulous means by which Socialists endeavour to saturate the minds of infants with their pernicious doctrines." From the daily appearance of our Front Surgery and Out-Patient Department, it might be inferred that the minds of the infants in the Borough refuse to be saturated.

THE annual Commemoration Day at Livingstone College, which is held this afternoon, is to be an event of special importance this year, as it is expected that a number of delegates to the World Missionary Conference will attend, and an address on "The part to be played by Missionaries in the Campaign against Malaria" is to be delivered by Professor Ronald Ross, C.B., F.R.S.

IN our correspondence column will be found a letter from Dr. Lauriston Shaw, the Hon. Sec. of the Executive Committee of the Annual Meeting of the British Medical Association, which is to be held in London in July, pointing out the importance to newly-qualified men who intend to join the Association of doing so in time to attend the Annual Meeting. We have also received a letter explaining that the Executive Committee is anxious that the Medical Students of London should have an opportunity of taking part in the scientific proceedings and social functions which have been arranged in connection with the meeting. As the space at their disposal makes it impossible to issue a general invitation to all students, the Committee desires to obtain a limited list of students in the school who would be likely to take advantage of such invitations as they are able to send. It must be pointed out that these invitations are necessarily restricted to unqualified students, as all qualified men are, of course, eligible for membership of the Association. It is therefore suggested that the names of students who would like to avail themselves of this invitation, if possible, should be sent to the Editor of the GAZETTE so that a list may be prepared.

Two important Swimming Fixtures are to be held at the end of this month. The Guy's Swimming Gala is fixed for June 29th, and will be held at the Southwark Baths, Lavington Street, and the University of London Swimming Meeting will be held on June 27th at the Lambeth Baths. Further particulars will be announced in our next issue.

IT is announced that the Annual Garden Party and Prize Day will be held on Thursday, July 7th, and that Professor Howard Marsh, of Cambridge, has promised to distribute the prizes.

THE results at our Guy's Annual Athletic Sports held last Saturday justify us in the belief that our men will do well at the Inter-Hospital Competitions, and that we have a very fair chance of winning the cup, which we so nearly won last year. The United Hospitals Sports are to be held at Stamford Bridge on Friday, June 24th, and it is to be hoped that a large number of Guy's supporters will attend, and help to infuse enthusiasm into their champions. The attendance as a whole last year was ridiculously small considering the interesting nature of the meeting, which in former years was attended by a crowd second only in size to that seen at the Rugger Final. Another athletic meeting at which Guy's should do well is that of the University of London Union, which will be held at Stamford Bridge on June 16th.

Guy's Hospital Ladies' Association.

THE Fifteenth Annual General Meeting of Guy's Hospital Ladies' Association was held in the Court Room on Thursday, May 26th, at 3.30. In the unavoidable absence of the Duchess of Sutherland, who was to have presided, the Countess of Bective took the chair, and amongst those present were:—Mrs. Benyon, Mrs. Bonsor, Mrs. Francis Lucas, Mrs. Merry, Mrs. Kenneth Campbell, Mrs. Hale White, Mrs. Lane, Mrs. Symonds, Lady Fripp, Lady Perry, Miss Haughton.

The proceedings were begun by the passing of a vote of sympathy to the President of the Association on the death of His Majesty King Edward VII., which was moved by Lady Bective, seconded by Mrs. Benyon, and assented to by the meeting in silence, standing. After the minutes of the last meeting had been confirmed, the Hon. Treasurer, Mrs. Pye-Smith, read the audited statement of accounts for the year ending March 31st, 1910. In moving the adoption of the financial statement, Mrs. Hale White referred to its satisfactory character, inasmuch as the annual income was rather larger than that of the corresponding period last year. She thanked the branches for their increased support, and congratulated them upon the very small amount of their expenses, which was in all only £10. She also thanked Mr. Wells for the great help he had now for several years rendered the Association by auditing the accounts and giving them valuable financial advice. For the third year in succession the Association was able to give the Hospital £300 to support six beds, in addition to £25 contributed by the Junior Members for the support of a Cot in Esther Ward. The resolution was seconded by Mrs. Stanley Mason, and carried unanimously.

The adoption of the Annual Report was moved by Mrs. Benyon, who said it was as usual a pleasure to undertake this duty, as the Report was always a favourable one. The Committee much regretted the loss of Miss Swift's help, but she felt sure that the sympathetic relations existing between the Association and the Matron would be continued under Miss Haughton. The increased number of members was entirely due to the exertions of the local branches, which were the mainstay of the Association. They were greatly indebted to Mrs. Strode, who acted as Hon. Secretary to two branches, one of which, that at Streatham, was the largest branch of all. She was struck by the fact, in reading the reports, that Mrs. Strode had an annual meeting of her branches. She thought this a very good idea, and one which might well be followed by other branches. It increased local interest in the work, and helped to secure fresh support. She must also refer to the beautiful garments contributed by the Denmark Hill and Blackheath branches, and to the sale of work held by Mrs. Blatherwick, at Dulwich, which resulted in a cheque for £190 6s. 3d. being handed in to the Hon. Treasurer. This would be used to support an additional bed in Victoria Ward for a term of four years. Miss Haughton seconded the resolution, and thanked the members for all they were doing to provide garments for the patients. Their work was greatly appreciated by the nursing staff, and they might feel that they were helping the very poorest of the patients by providing them with clothes to go to Convalescent Homes. The hospital itself was also saved a large sum every year through the many garments and other accessories for ward use provided by the Association. She appealed to ladies in other districts to start branches so that Guy's might have a chain of centres all round London working for it.

Mrs. Arbuthnot Lane moved, and Mrs. Layton seconded, the election of Lady Fripp and the Hon. Mrs. Henry Molyneux, to fill the vacancies on the Committee caused by the retirement of the Hon. Mrs. Kenneth Campbell and Mrs. Hale White, and Miss Haughton was chosen to replace Miss Swift, who had resigned.

Mrs. Cosmo Bonsor moved a very cordial vote of thanks to Lady Bective for her kindness in coming to take the chair, which was carried with acclamation. Lady Bective, in replying, said there were two things to which she would like to refer briefly. The first was the possibility in the near future of being able to support all the eight beds in the Maternity Ward. This year the Association was reponsible for the upkeep of seven, and they much hoped that the one poor little bed left out would soon become their property also. She therefore appealed to members to get increased support so as to make this possibility a certainty next year. Secondly, she wished to draw attention to the immense field for usefulness open to the Ward Visitors. It was a great work and meant much more than just saying a few words, or reading. It meant hearing confidences, and listening to sorrows, and wants, and where possible acting on the information thus received. It was well to realize the bad effect, nay, even the danger to life, caused by anxiety about those at home in the minds of patients, which fact had been prominently brought out in the Report. Visitors with common sense and kind hearts could do a great deal, and she appealed for more help in this direction. Not only did such visitors help the patients, but they brought into the hospital a fresh atmosphere, they enlarged the surroundings, and to a certain extent prevented the danger to which a large institution was liable, of becoming hide-bound.

After the meeting all the members present were entertained at tea by Mrs. Benyon and Mrs. Bonsor, Lady Perry kindly lending her house for the purpose. A large number of members were afterwards taken by Hospital Sisters to see the Wards, the Light, and X-ray departments.

Papers, etc., Received.

"A Guide to the Preservation of Health in West Africa," by Henry Strachan, C.M.G., M.R.C.S., L.R.C.P. (Constable & Co.) 6d. net.

Doctor Topthorn's Success.

YOUNG TOPTHORN had left the Borough Hospital and had settled down behind a large brass plate in Pimlico. His practice was not prospering, and he was getting sick of waiting for better times. Chance led him to call upon an old hospital friend who practised on Campden Hill, and to him he confided his woes.

"My dear fellow," said Vynon, as he lit a cigarette, "you lack the professional manner. Medicine is all bosh. It is manner, personality—that is the thing. If you take my advice, with those bushy eyebrows of yours, you will model yourself upon the late Sir William Gull."

Topthorn was struck with the idea, and forthwith asked his friend to instruct him how to become Sir William Gull.

Six months later Topthorn crawled up Campden Hill and called on his instructor.

"It's no good, Vynon," said he, as he sank into a chair, "Sir William has been a failure in Pimlico. I did all I could. I lowered my eyebrows at my patients; I stalked about the room in deep thought; I tried the 'Sherry' story upon secret drinkers, I placed my finger upon the exact seat of disease a dozen times, *à la* Gull. But it was no go. One man, indeed, said he hadn't come there to be insulted, while a woman said if she had known what I was like she'd have gone to the hospital!"

"Well," said Vynon, "it's evident Sir William Gull does not go down in Pimlico. Suppose you try Sir William Jenner, now? His method was different."

"Anyone else but Gull," said Topthorn, with a sigh.

Again Vynon instructed his friend how to be someone else. The Jennerian tradition was carefully studied. Topthorn had to grow a stubbly moustache and whiskers, learn to pout his lips, to raise his eyebrows till they almost vanished into his locks above, to sit huddled up in his chair when interviewing a patient, and, above all, to be positive in his diagnosis.

"I, Doctor Topthorn, tell you that you are suffering from an ulcer of the stomach," was to give the true Jenner note.

Another six months passed, and a disappointed man again appeared before Vynon.

"Jenner won't do either," he said. "You know I was too positive in diagnosis. I found I was generally wrong. You see, the worst of being positive, one must know such a lot. Now the real Jenner——"

"Yes, yes, I know. Well, perhaps they are out of date, these departed ones. Suppose you try one of the living, eh? What about Nearley-Fitt, or even Figge-Brown?"

"My dear Vynon, I couldn't do it. Fitt is good-looking, and has a charm of manner that cannot easily be acquired, while Figge-Brown looks a pocket Socrates."

"Well, what do you say to Goodman?"

"I don't know. He certainly is a success."

"Of course he is. But you must grow a beard, and pull at it, and train it to fly out in the wind. Your hair is the right colour, but mind, cut it *yourself*—every three months. Then wear a flowing tie and an extra watch chain, *à la* Byron. Be genial, very genial. Bubble over with mirth at the slightest approach to humour on the part of your patients. Cultivate a 'chuckle,' and trot it out as you auscultate. Tell them they'll all get well if they'll only wake up and dig in the garden, or sweep a crossing. Clap 'em on the back, pinch their elbows. Let them leave your consulting room amidst a whirl of stirring words that sound much but mean nothing, and—and—you'll be a success!"

Once more Topthorn departed, full of hope of becoming a second Goodman.

A year passed before he appeared again on Campden Hill. Vynon was struck with his quiet and somewhat stupid manner.

"My friend," he said, "are you still a failure?"

"No," stolidly replied Topthorn.

"What, has Goodman then wafted you into favour?"

"No," replied Topthorn, leisurely taking a seat.

"Have a drink—a cigar?"

"No, thanks. I never take anything. I never do anything."

"And you say you are a success?"

"A great success," was the calm reply.

"What do you mean, Topthorn?"

"I mean that I tried being Gull, and failed. I tried being Jenner, and equally failed. Then I took Goodman as my model, and nearly did for myself over one case through trying to make a Quaker laugh. In despair I became nobody. I sank into myself, as it were, and hardly spoke to my patients. Now I just look at them and prescribe. If I do ask a question it is generally about the ailments of their grandparents. This excites their interest; it whets their curiosity. They come again to see if they can find out more. All they get, however, is a question about their more remote ancestors. This becomes more mysterious. The less they understand you the more they believe in you. They

talk to their friends, they bring their friends, and—thus things go on, and I am at last a great success."

Vynon listened gravely, and, after a pause, said—

"My dear Topthorn, it strikes me you have gone back much further than Gull and Jenner for your successful methods. I consider you have revived the practice of a century ago. Patients, then, like their doctors, knew nothing, and the result was entire confidence in the doctors. We explain too much nowadays. We are for ever teaching our patients our business. You are on the right tack. I congratulate you. I see you carry a gold-headed cane. Let me present you with that old snuff-box I picked up in a Soho shop the other day. Then you will be quite 'in the picture.'"

FREDERIC VICARS.

Pass List.

Royal College of Surgeons of England.

FINAL EXAMINATION FOR F.R.C.S.

Kenelm H. Digby.

University of London.

THIRD (M.B., B.S.) EXAMINATION FOR MEDICAL DEGREES, MAY, 1910.

HONOURS.

T. D. M. Stout (*a*).

(*a*) Distinguished in Medicine.

PASS.

E. L. Elliott.	N. L. M. Reader.
H. Gardiner.	T. Stansfield.
G. Maxted.	C. C. Tudge.

GROUP I.

W. S. Kidd. | C. Witts.

GROUP II.

A. Neville Cox. | A. E. Lees.

R. Montgomery.

Medical Department, Royal Navy.

D. A. Mitchell.

PERIODICALS RECEIVED.—The Hospital; The Clinical Journal; The Nursing Times; St. Bartholomew's Hospital Journal; South African Medical Record; The Polyclinic; The Prescriber; Middlesex Hospital Journal; Calcutta Medical Journal; Manchester Medical Students' Gazette; Manchester University Magazine; London Hospital Gazette; St. George's Hospital Gazette.

A Reminiscence of Professor Robert Koch.

TEN years ago (October, 1900) I had the good fortune to be in the closest touch with the late Professor Koch for a week, whilst on a voyage from Alexandria to Marseilles in the old P. & O. steamer "Valetta." I was ship's surgeon, and there being only half-a-dozen passengers the Professor and I spent many hours together. Koch was of medium height, of solid German build, his eyes keen and eager behind gold-rimmed glasses. The very air of the man was authoritative. To me, a young surgeon, he was most courteous and kind. We played chess, and I remember with pride how I mated him one afternoon, after, I must confess it, he had allowed me a knight. A young officer, the son of a distinguished admiral, was taken ill on the voyage. Dr. Koch kindly visited his cabin at my request, and drew a drop of blood for the purpose of making a blood film. The microzoon of malaria were not found. Without a moment's hesitation the Professor pronounced the disease to be typhoid, and advised me immediately to place the patient in the continuous bath. The subsequent course of the disease proved it to be Malta fever. One afternoon we passed a group of small islands, which the Professor declared to be of sedimentary rock. No argument would turn him from this view, although they are really of volcanic origin. These two episodes show the dogmatic character of the man. He attributed the failure of the famous serum, which it was hoped would cure phthisis, to the mixed nature of the pulmonary infection which, he said, occurred at the very outset of the disease.

Dr. Koch was returning to Berlin, after spending eighteen months in tropical Africa studying malaria. Before me, as I write, lie the notes I made immediately after a talk with him about the malarial parasite and the *Anopheles* mosquito. His researches amply confirmed Ross's discovery of the rôle the mosquito plays in transferring the microzoon from man to man. On leaving the ship Dr. Koch invited me to visit him in Berlin. The memory that abides with me is of a man of keen scientific temper, dogmatic of temperament, somewhat intolerant of criticism, withal large-hearted and kindly.

VAUGHAN PENDRED, M.D., F.R.C.S. Eng.

Coventry.

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

British Medical Association.—London Meeting, 1910.

DEAR SIR,—In view of the annual meeting of the British Medical Association, in London, in July next, from the 26th to the 30th inclusive, a letter has been addressed to all medical practitioners who are not members of the Association inviting them to join the Association in time to take part in the meeting.

It is recognised that recently-qualified medical men whose names are not in the Directory will not receive this circular, and I would therefore venture to ask you to allow me to address an invitation to such men in your school, through the columns of your Journal.

A very large attendance of members is expected, and the meeting is likely to prove an interesting one, both from the scientific and social point of view. Full particulars of the programme and general arrangements will be found, from time to time, in the *British Medical Journal*.

It may not be out of place to remind your recently-qualified students that, apart from the occasion of this annual meeting, membership of the Association is both a duty and privilege which should hardly be neglected by any member of the profession.

Enclosed are some forms of application for membership, which, perhaps, you would be kind enough to hand to some official of your school, informing your readers in a postscript to this letter whence they can obtain them.

—With many thanks, I am, yours faithfully,

LAURISTON E. SHAW,
Hon. Local Secretary, 1910 Meeting.

[Recently-qualified readers who have not yet joined the British Medical Association may obtain forms of application for membership from the Librarian.—ED. G.H.G.

The Biennial Dinner, 1910.

DEAR MR. EDITOR,—The following list includes the names of all old Guy's men who have accepted the invitation to the Biennial Dinner up to to-day. In the next issue of the GAZETTE the final list of acceptances will be published, and I hope that the number may be doubled by that time.

Adeney, E. L.
Ashwin, R. H.
Aubrey, H. P.
Austen, H. H.
Baillie. R. A.
Beale, E. Clifford.
Beard, F.
Beddard, A. P.
Black, G.
Blatherwick, H.
Bosworth, J. R.
*Brailey, A. R.
Brailey, W. A.
Brogden, R. W.
Brookhouse, C. T.
Brookhouse, H. O.
Brown, Thomas.
Bryant, Thomas.
Bryden, R. J.
Burghard, F. F.
Busteed, J. H.
Buxton, A. St. Clair.
Cameron, H. C.
*Camps, P. W. L.
Cardin, H. C.
Carlyll, H. B.
Chapple, H.
Chisolm, R. A.
Cleveland, A. J.
Cloud, F. H. L.
*Clowes, E. F.
Cock, F. W.
*Cook, W. W.
*Cooper, H.
Counsell, H. E.
Craig, M.
Crofts, A. D.
*Cross, F. G.
*Cutler, H. A.
Daldy, A. M.
*Davy, H.
Digby, K. H.
Dunn, L. A.
Durham, F.
Edwards, C. D.
Elcum, D.
Elphinstone, R.
Ewart, J. H.
Eyre, J.
Fagge, C. H.
Fawcett, J.
Fisher, W. H.
Fisk, E.
Flower, N.
Forsyth, D.
Fothergill, E. R.
Fremantle, F. E.
Gibson, J. H.
Gillingham, A.
Goadby, K.
Golding-Bird, C. H.
Goss, J.
Gough, B. B.
Greenwood, E. C.
Handley, W. S.
Hertz, A. F.
Higgens, C.
*Hills, W. E.
Hopson, M. F.
Howell, T. A. J.
Hughes, E. C.
Iredell, C. E.
*Jalland, W. H.
Jewell, J. W. F.
Jones, C. E. M.
Key, M. Aston.
Knowles, C. H.
Laidlaw, P. P.
Lansdown, R. G. P.
Layton, T. B.
Leipoldt, C. L.
Lipscomb, E. H.
Little, E. Graham.
Lund, H.
*McGavin, L. H.
Maggs, W. A.
Malleson, H. C.
Mann, H. C.
Mansell, E. R.
Matcham, A.
Millbank-Smith, H. J.
*Miller, A. A.
Miller, W. H.
Minns, P.
Mollison, W. M.
Moore, J.
*Morgan, E.
*Mullins, H. R.
*Munro, H. A.
Nash, W. G.
Newnham, W. H. C.
Nicholls, F. J.
Nichols, R. T.
Ormond, A. W.
Pavy, F. W.
Payne, J. L.
*Payne, O. V.
*Pendlebury, J. F.
Perry, E. C.
Pinching, Chas.
*Pinching, C. J. W.
Pitt, G. N.
*Rand, J.
Randall, P. N.
*Randell, R. M. H.
*Ray, E. R.
Rippmann, C. H.
Roberts, A. C.
Robinson, W. E.
*Routh, C. F.
Rowland, E. W. S.
Rowland, W. J.
*Sangster, C.
Savage, G. H.
Scott, A.
Scott, B.
Scott, M.
Shaw, L. E.
Shipway, F. E.
*Sichel, G.
Smith, D. W.
Starling, E. A.
Stevens, T. G.
Stewart, H. M.
*Stokes, L.
Symonds, C. J.
Tanner, John
Targett, J. H.
*Taylor, A. S.
Taylor, J. G.
Thomas, J. D.
Thomas, T. P.
Thornely, M. H.
*Ticehurst, G. A.
Trail, D. H.
Tulk-Hart, C. J.
Turner, F. M.
Turner, George.
*Tyson, W.
Uhthoff, J. C.
Vandermin, H. F.
Vicars, F.
Wacher, S.
Walters, J. B.
Way, M.
White, W. Hale
*Wilks, H. L. E.
Woodhouse, C.
Young, F. C.
Younger, E. G.

* Vice-Chairmen.

I am, Sir, yours sincerely,

66, Wimpole Street, W. JOHN FAWCETT,
June 8th, 1910. *Hon. Sec.*

Flatulence.

CLINICAL LECTURE BY A. F. HERTZ, M.D.

GENTLEMEN,—Probably more patients complain of flatulence than of any other symptom, yet it is a condition which is hardly described at all in the text-books, so I thought it would be useful to discuss its causes and treatment in my lecture to-day.

I.—PHYSIOLOGY OF THE GASES OF THE ALIMENTARY CANAL.

(A) THEIR ORIGIN.
- (1) Bacterial decomposition.
  - (a) Fermentation of carbohydrates (i) in stomach, (ii) in intestines.
  - (b) Putrefaction of proteins—in intestines only.
- (2) Swallowed air.
- (3) Aërated drinks.
- (4) CO_2 produced by the action of the gastric HCl on the alkaline carbonates of saliva and food.

N.B.—No gas diffuses from the blood-vessels of the mucous membrane.

(B) THEIR ELIMINATION.
- (1) Absorption.
- (2) Expulsion—
  - (a) From the stomach: normally none.
  - (b) From the intestine.

Before talking about flatulence, it is necessary to consider the physiology of the gases which are present under normal circumstances in the alimentary canal, the sources from which they are derived, and the means by which they are eliminated. Normally, the quantity which is produced in or introduced into the alimentary canal is equalized by the amount which is eliminated, so that the total quantity remains fairly constant.

The gases of the stomach and intestines are derived from two main sources—(1) bacterial decomposition, and (2) air swallowed with food and saliva. With regard to the gases produced by bacterial decomposition, two groups must be distinguished—(a) those resulting from the fermentation of carbohydrates, and (b) those due to the putrefaction of proteins. Fermentation of carbohydrates occurs normally to a slight extent both in the stomach and in the intestines. Putrefaction of proteins does not, under normal conditions, occur in the stomach, and consequently the gases which are obtained from the stomach are odourless. On the other hand, a certain amount of protein putrefaction normally occurs in the intestine, particularly in the colon, and as a consequence gases expelled from the large intestine always smell to some extent of putrefactive products.

The gases introduced on swallowing are of great importance. Every time a mouthful of food or fluid is swallowed a certain amount of air is swallowed with it. This occurs not only at meals, but also whenever saliva is swallowed. A considerable quantity of gas is sometimes also introduced by the drinking of aërated waters.

A small quantity of carbon-dioxide is normally produced by the action of the hydrochloric acid of the gastric juice on the alkaline carbonates of the food and saliva. This occurs more particularly with vegetable foods, because they contain a greater quantity of alkaline carbonates than animal foods. It has often been said that gas may diffuse from the gastric and intestinal mucous membrane, but in all probability this never really occurs.

Now with regard to the elimination of gas from the alimentary canal, the greater part is absorbed by the mucous membrane. Oxygen is taken up with extreme ease and rapidity, so that although a considerable amount of oxygen is swallowed with the air, under normal conditions none is present at all in the large intestine; it is all absorbed in the stomach, and, to a less extent, in the small intestine. Enormous quantities of other gases can be absorbed under special circumstances; this is well seen in the rapid absorption of carbon-dioxide after large quantities of aërated drinks have been taken, when an excess of gas is not necessarily passed either by the mouth or the rectum.

Normally no gas is expelled by eructation, but a varying quantity is expelled from the rectum as flatus. Eructation, however, serves as an additional means of elimination whenever excess of gas is present in the stomach.

II.—EXCESS OF GASES IN THE ALIMENTARY CANAL. FLATULENCE.

(A) EXCESSIVE PRODUCTION AND INTRODUCTION OF GAS.
- (1) Excessive bacterial decomposition.
  - (a) Excessive fermentation (i) in stomach, (ii) in intestines.
  - (b) Excessive putrefaction (i) in stomach, (ii) in intestines.
- (2) Aërophagy.
  - (a) Associated with dyspepsia.
  - (b) Hysterical.
- (3) Excessive quantities of aërated drinks.

(B) DEFICIENT ELIMINATION.
- (1) Deficient absorption, due mainly to catarrh of stomach or intestines.

(2) Deficient expulsion.
(a) From the stomach (i) upwards (only if excess present owing to other causes: (*a*) voluntary, (*b*) gastric atony), (ii) downwards in pyloric obstruction.
(b) From the intestine (*a*) voluntary, (*b*) constipation.

I have not drawn up separate tables for gastric and intestinal flatulence, because, although one is often able to say whether the excess of gas is mainly in the stomach or mainly in the intestine, the two conditions are generally associated together.

The causes of flatulence may be classified under two headings: *A*. Excessive production and introduction of gas; and *B*. Deficient elimination of gas.

A. EXCESSIVE PRODUCTION AND INTRODUCTION OF GAS.

This is due to (1) excessive bacterial decomposition; (2) aërophagy; and (3), as a cause of occasional and temporary flatulence, the consumption of excessive quantities of aërated drinks.

1. *Excessive bacterial decomposition* has generally been considered to be the most important cause of flatulence, but, as a matter of fact, it is very much less common than aërophagy. Bacteria are introduced into the alimentary canal mainly in the food, and to a less extent in water; a septic condition of the mouth, and especially pyorrhœa alveolaris, is an additional source in many people.

Excessive bacterial decomposition may be due (*a*) to fermentation, or (*b*) to putrefaction, and both processes may occur either in the stomach or in the intestine. It has long been believed that the free hydrochloric acid in the stomach affords protection against gastric and intestinal fermentation and putrefaction, and that this is one of the chief functions of the gastric juice. But one finds a number of cases of hyperchlorhydria in which excessive bacterial decomposition, particularly of carbohydrates, occurs. For example, in pyloric ulcer there is a considerable excess of hydrochloric acid in the stomach all day, and not merely when food is present. There is also more or less stasis of the food in the stomach, because an ulcer situated near the pylorus interferes with evacuation. Under these conditions, in spite of the hyperchlorhydria, a considerable degree of fermentation often takes place. On the other hand, there is a condition known as achylia gastrica, in which no gastric juice is produced at all, but its frequency has only comparatively recently been recognised, because in many cases it causes no flatulence or other symptoms. It is apparently in most instances a congenital condition, and the patient may live for many years without being any the worse for it. But when there are symptoms, they are more frequently intestinal than gastric, diarrhœa being the most frequent. The diarrhœa is not, however, produced by organisms so much as by the food in the stomach being insufficiently digested, and so acting as a mechanical irritant to the intestinal mucous membrane. Hyperchlorhydria does not therefore always prevent excessive bacterial decomposition, and absence of hydrochloric acid in the stomach may occur without increase of bacterial decomposition. It is, in fact, probable that the secretion of the intestinal juice is more important than that of gastric juice in preventing fermentation. You know that carbohydrate digestion under normal conditions is absolutely complete; no carbohydrates, except cellulose, appear in the fæces, the digestion occurring as a result of the action of saliva, pancreatic juice and succus entericus. Under certain conditions the intestinal juice or its diastatic and sugar-splitting ferments appears to be diminished, and consequently most of the carbohydrate, which has escaped the action of the saliva and pancreatic juice, remains undigested and undergoes bacterial decomposition. This is probably the chief cause of an important, but insufficiently recognised cause of abdominal discomfort,—*intestinal fermentative dyspepsia*.

An excessive quantity of food may lead to a certain amount of bacterial decomposition in the stomach, because it is impossible for the gastric juice to impregnate a large mass of food sufficiently. This is particularly the case when it has been insufficiently chewed; and individuals who eat too much and too quickly are more commonly troubled with excessive bacterial decomposition, both of carbohydrates and proteins, than any others, the dyspepsia which is ascribed to gout and to "plethora" being in most cases really a result of this.

The influence of diet on flatulence of bacterial origin is, of course, considerable, the amount of fermentation depending on the quantity of carbohydrate in the food, and that of putrefaction on the quantity of protein. These considerations are of considerable importance in treatment.

The most important factor in connection with bacterial decomposition is stasis. One knows, for example, that decomposition occurs much more in stagnant water than in running water, and in the pathology of the hollow viscera, such as the gall-bladder and the urinary bladder,

the ease with which decomposition occurs when there is obstruction to the outlet is well known. It is, therefore, not a matter of surprise that an extremely important cause of decomposition in the stomach is obstruction at the pylorus. A very good example showing the relative importance of stasis and the presence of hydrochloric acid is in the case of cancer of the pylorus; in this condition there is often complete absence of free hydrochloric acid in addition to stasis, and as a result there is a considerable degree of bacterial decomposition, particularly of carbohydrates. If gastro-enterostomy is done, the stasis is relieved, but no increase in the hydrochloric acid occurs. In spite of that, the excessive bacterial decomposition at once diminishes, and often entirely disappears. This shows how much more important stasis is in the stomach than the presence or absence of hydrochloric acid.

With regard to the intestines, stasis is only important when it is absolute. In cases of intestinal obstruction, the quantity of gas produced by bacterial decomposition in the intestine is enormous, and one of the most characteristic symptoms of the intestinal paralysis in advanced peritonitis is the distention of the intestines with gas. But a lesser degree of stasis, such as that present with constipation, is not associated with increased decomposition; it has indeed been definitely proved that in constipation the number of bacteria present and the amount of putrefaction in the alimentary canal are diminished. Much of the recent talk about intestinal auto-intoxication in constipation is therefore devoid of any foundation in fact.

Whenever gas brought up from the stomach has any smell, it must be due to bacterial decomposition, and flatus which smells abnormally strongly and unpleasantly is a result of abnormal bacterial decomposition; it is often possible to recognize from the smell whether there is excessive fermentation or excessive putrefaction. Sometimes a little food is brought up with gas from the stomach; if it has an unpleasant and not merely acid taste, it is indicative of excessive bacterial decomposition, even if the gas is odourless.

In addition to the gases produced by excessive bacterial decomposition, other abnormal substances are formed, which irritate the mucous membrane. In the stomach catarrhal gastritis may result, and there may be vomiting; a similar catarrh is produced in the intestine, and diarrhœa frequently occurs. Excessive bacterial decomposition may be accompanied by general symptoms; the tongue is furred, the patient complains of general malaise, and there may be some pyrexia.

A simple method of ascertaining whether excessive fermentation or putrefaction is occurring in the intestine has been devised by Schmidt and Strasburger. A small quantity of fæces is mixed with sufficient water to fill a bottle connected with a tube filled with water, which is driven into a second tube when any gas collects in it. If kept at the body temperature for twenty-four hours, normally little or no gas is produced. If a moderate or considerable quantity collects, it may be assumed that abnormal bacterial decomposition is occurring in the intestine. The smell of the gas will show whether this is fermentation or putrefaction. Moreover, if the fæces become definitely acid, there must be excessive fermentation; if alkaline, excessive putrefaction. This investigation is very important as a guide to treatment, because many cases of chronic diarrhœa which have not improved at all with antiseptics and other drugs improve at once as soon as the diet is changed in the direction indicated by the results obtained.

2. *Aërophagy.*—Aërophagy is the commonest of all the causes of flatulence. In most cases it is associated with dyspepsia, and particularly with nervous dyspepsia, but it may also be associated with organic diseases such as gastric and duodenal ulcer. In such cases the patient feels some slight discomfort in the stomach, which he thinks must be due to "wind," and he imagines that he can "disperse" it by means of eructation. But in the vast majority of cases the attempt to eructate is unsuccessful, as there is really no excess of gas present in the stomach, and the unsuccessful attempt results in the swallowing of air. Often half a dozen or more attempts are made without success, air being swallowed at each attempt. The stomach becomes so distended with gas that an attempt is at last successful, the gas expelled being odourless, because it is nothing but air.

In gastric disorders associated with hyperchlorhydria, such as gastric and duodenal ulcer, there is a reflex excessive flow of saliva, the reflex being presumably an attempt to protect the gastric mucous membrane by the production of an excess of alkaline saliva, which will partially neutralise the too acid contents of the stomach. The secretion of excessive saliva leads to frequently repeated deglutition, and every time saliva is swallowed some air is swallowed with it. Consequently in nearly

every case of gastric and duodenal ulcer the patient is much troubled with flatulence.

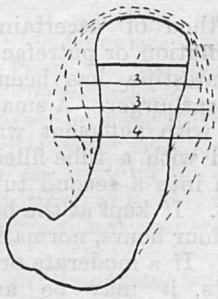

Fig. 1.—Diagram to illustrate aërophagy.

The tracings thrown on the screen (fig. 1) show how the X-rays have demonstrated what actually happens in these cases. The continuous outline is reproduced from a tracing of the stomach taken immediately after a bismuth meal had been taken by a patient who was suffering from severe flatulence; the horizontal line 1 shows the upper level of the gastric contents. The patient now felt some discomfort and made an attempt to eructate, and indeed thought she had eructated. But as a matter of fact, there was an increase and not a diminution in the amount of gas present in the stomach, the upper level of the gastric contents becoming depressed to 2; the successive levels 3 and 4 were reached as the result of repeated attempts to eructate, air being swallowed each time. At last the patient really did eructate, bringing up a large quantity of air with a loud noise; the upper level of the gastric contents at once rose to 1 again.

The severest cases of aërophagy occur in hysterical women, independently of any dyspepsia. Such patients may swallow enormous quantities of air, which they pump from the stomach into the œsophagus and back again by spasmodic movements of the diaphragm. I had one such patient in hospital last year, a woman who was well whilst lying down, but when she sat up she made a rythmical noise which was heard all over the ward, enormous quantities of air being pumped in and out of the stomach. On compressing her abdomen the explosive sound was replaced by a long sighing inspiration.

The diagnosis of aërophagy is very important, because it is customary to treat the majority of cases of flatulence as if they were due to abnormal bacterial decomposition, although most are really the result of aërophagy. When a patient makes a series of attempts to eructate it is very probable that aërophagy is present, particularly if he is neurotic; if more than six attempts are made before any gas is brought up the diagnosis is almost certain. Very large quantities of gas are expelled under no other circumstances. If a patient has no pyloric obstruction, but is troubled with flatulence before breakfast, it must be due to aërophagy, because in the absence of pyloric obstruction it is impossible for bacterial decomposition to occur in the stomach during the night. When the gas is odourless, and any gastric contents which may regurgitate with it taste merely acid, it is probably swallowed air.

B. Deficient Elimination.

1. Probably there is a somewhat deficient absorption of gas in cases of catarrh of the stomach and intestine.

2. Deficient expulsion of gas, except in association with constipation, is not of great importance. If excess of gas is present in the stomach the flatulence can be relieved by eructation. The symptoms are therefore aggravated if the stomach is so atonic that its muscular power is not sufficient to expel it.

Voluntary retention of gas in the stomach or intestines for the sake of decency, especially when gas is present in excess, prevents the natural mechanism of relieving flatulence. The Emperor Claudius made an effort to overcome the popular opinion that to allow the escape of wind is an offence against decent manners by issuing an edict, which made it lawful for any Roman "*flatum crepitumque ventris in convivio emittere.*" Pyloric obstruction prevents the rapid passage of gas as well as fluids into the duodenum, so that the gas which is likely to be produced in excess in such cases tends to accumulate in the stomach.

Constipation, as I have already said, does not lead to excessive decomposition. But when fæces move with abnormal slowness along the colon, although they hardly ever produce complete obstruction, they may be so tightly hugged by the surrounding intestine that the gas which is behind them cannot pass, and so in addition to the retention of fæces there is retention of gas. Hence in constipation flatulence is often very troublesome, and it is generally associated with more or less colic; a characteristic feature of this form of colic being the immediate and complete relief which follows the passage of flatus.

3. *Pseudo-flatulence*: (*a*) spasm of the diaphragm; (*b*) imaginary flatulence.

There are some people who complain of flatulence which does not really exist at all

All such patients are neurotic. The most common form of pseudo-flatulence is due to spasm of the diaphragm. If a patient tells you that quite suddenly, without obvious reason, her abdomen gets enormously distended, and that she can never expel gas either from her stomach or her rectum, but that in spite of this the distention suddenly disappears without obvious reason, you can diagnose the condition with a considerable degree of confidence. This cause of pseudo-flatulence was first recognized when it was found that on giving certain patients with enormously distended abdomens an anæsthetic, the distention disappeared, although no gas was expelled. I have examined one typical case in a neurotic woman with the X-rays; the stomach was found to contain no excess of gas, but a tonic spasm of the diaphragm was present; the diaphragm was so low that the abdominal contents pushed the anterior abdominal wall forward, producing the appearance of extreme flatulent distention. On persuading the patient to breathe properly with her diaphragm the pseudo-flatulence disappeared.

The second class of pseudo-flatulence is harder to treat, the condition being entirely imaginary, as there is not even any abdominal distention. Most of these cases are on the border line of insanity. I recently saw an Indian civilian who had come home in the hope of obtaining relief from the "flatulence," which was making his life almost unbearable. On going into the question with great care, one found that he had never to his knowledge brought up gas, nor passed flatus—a fact which only increased his misery, as it showed him that he also suffered from "incontinence of the rectum." He was convinced that he constantly passed offensive flatus, because whenever he entered a railway carriage, the other occupants got out at the next station, and whenever he dined at a restaurant people got up and went out. Everybody he met seemed to notice that he was passing stinking flatus, although he admitted that he had never smelt it himself. This was, in fact, a case of obsession. He had been treated with all sorts of antiseptics, sour milk and vaccines, but in vain. We tried to persuade him there was nothing really the matter, but he has returned to India only half convinced, and I fear that he may end by committing suicide.

In another case the obsession was on the part of the patient's husband, a medical man, who found it impossible to live in the same house as his wife, owing to the smell which he said she emitted. It turned out that her stools were quite normal, and she never passed flatus, the smell only existing in the imagination of the husband.

Symptoms.—The most constant symptom resulting from flatulence is a sensation of fulness in the abdomen. The abnormal accumulation of gas in the alimentary canal also pushes the diaphragm up, with the result that dyspnœa may be produced; this is specially the case in those who, for other reasons, are subject to dyspnœa. There is nothing more likely to cause an attack of asthma, or to make an attack worse, than flatulence; and the same applies to the dyspnœa of heart disease. The high position of the diaphragm may lead to palpitation, and even to attacks of pseudo-angina pectoris; and in genuine angina pectoris flatulence may be the exciting cause of an attack.

The distention produced by an excessive quantity of gas in the alimentary canal acts as a stimulus to peristalsis, and the sulphuretted hydrogen which results from protein decomposition is a powerful intestinal irritant, so that flatulence is often a cause of colic. This is severest in cases associated with constipation, as in them there is also an abnormal resistance to the passage of flatus. A common cause of constant screaming in infants is the colic produced by flatulence. Distention increases the amount of work which the stomach and intestine have to do; at first this is neutralised by the stimulating effect of distention, but when long continued the muscle begins to fail, and a condition of atony results.

Treatment.—The first essential in the treatment of flatulence is to make an accurate diagnosis, as it is clearly futile to treat aërophagy by antiseptics, or excessive fermentation by psychotherapy. Having discovered the cause of the flatulence, an attempt should be made to remove the cause. To-day I can only discuss the treatment of the most important causes of flatulence—excessive bacterial decomposition and aërophagy.

1. In the treatment of flatulence due to abnormal bacterial decomposition, the diet is an important consideration. The food should be moderate in quantity and properly masticated. New bread and cheese are well known as being likely to cause flatulence, the reason being that it is difficult to masticate them properly, so that they are apt to be swallowed in lumps, which escape digestion by the gastric and intestinal juices, and are consequently subject to bacterial decomposition in the colon. When flatulence is due to bacterial decomposition it is essential to decide whether this is mainly carbohydrate or protein. If it is the former, a diabetic diet should be given; if the latter, protein-free diet

should be ordered for a short time. Often cases of diarrhœa which have lasted for months will be cured in two or three days by such means. The substitution of drachm doses of olive oil, alternating with diluted meat juice for peptonised milk, whey, or other milk substitute containing carbohydrate, will often lead to the rapid disappearance of the abdominal distention, due to excessive fermentation, which often accompanies the diarrhœa of infants.

Antiseptics have been given more than any other class of drug for flatulence, but it is of great importance to remember that they cannot possibly be of use except in the presence of excessive bacterial decomposition. Even in such cases their use is strictly limited, as antiseptics have very little action on bacterial activity in the intestine. Great care is required in selecting the drug for cases in which the excessive decomposition is in the stomach. Most of those in common use, such as creosote, also cause gastric irritation, and it is very important to avoid increasing the catarrh which is often already present. Many of the most popular drugs cannot act as antiseptics at all; the good they occasionally do must be a result of suggestion, and the flatulence which improves must be due to aërophagy and not to fermentation. Thus charcoal, which is still much used for supposed excessive bacterial decomposition in the alimentary canal, is absolutely inert as soon as it becomes moistened by the saliva. Such drugs as creosote owe their reputation partly to their strong smell, which drowns that of the products of bacterial decomposition. The drug of most use for excessive bacterial decomposition in the stomach is carbolic acid.

For abnormal bacterial activity in the intestine the administration of lactic acid organisms in sour milk is of much greater value than the so-called intestinal antiseptics. The lactic acid produced by the action of organisms from the lactose of milk prevents the development of most other organisms, and at the same time it acts as a mild stimulant to peristalsis. But there is no justification for the present extraordinary popularity of sour milk treatment. It is not a remedy which can be given indiscriminately, as it may produce severe gastric irritation and diarrhœa; it should only be used when it is quite clear that there is excessive bacterial decomposition in the intestine.

I must here warn you against most of the preparations of lactic acid bacilli on the market; almost all of those sold in tabloid form contain no living organisms, and many of the fluid preparations are either inert, or contain streptococci or other bacteria in much greater numbers than the lactic acid bacilli.

2. The successful treatment of flatulence depends largely on the treatment of aërophagy, as the majority of cases of any severity are due to this. It is often only necessary to explain to the patient what the mechanism of aërophagy is in order to cure him. Tell him not to try to eructate unless he is certain he will bring something up, and explain to him how the majority of his attempts result in an increase and not in a diminution of his flatulence. Tell him also to swallow saliva as little as possible. Many patients are cured instantaneously, but a few neurotic individuals cannot at first control the habit, but swallow and try to eructate more than ever. These severer cases are benefited by certain devices, which they can employ for a few days until they lose the habit. If the mouth is open it is impossible to swallow, so the patient should be told to open his mouth when he feels inclined to swallow or to eructate. In severer cases the patient should put a cork between his teeth under these circumstances, and the aërophagy will be prevented.

It is important to treat the dyspepsia, which has led to the aërophagy, by diet, alkalies, and so on. The patient will also want some rapid method of relieving his discomfort, as he is not allowed to eructate. Fortunately there are certain means by which relief can often be obtained at once. One is the drinking of hot water, but a tablespoonful of chloroform water is generally the most effective method. The reputation of some antiseptics and most carminatives is due to the burning sensation they produce, as this hides the feeling of discomfort, which leads to the aërophagy.

It is very important not to allow patients to take alcohol for their supposed flatulence. It often relieves the discomfort, but I have known a man become a chronic alcoholic through continually drinking whisky with the object of getting rid of the "wind," which was undoubtedly nothing more than swallowed air.

The only treatment of the severe cases of aërophagy, which are associated with hysteria, is by suggestion. The patient in Mary, to whom I have already referred, was relieved by passing a stomach tube, the tube being kept in the stomach for ten minutes at a time. So long as it was in position she could not eructate, and the mental effect was such that when it was taken out she stopped swallowing air. It is necessary to prepare such a patient beforehand,

by persuading her that she will certainly be cured by the treatment.

In conclusion, I must say a few words with regard to the symptomatic treatment of flatulence. Patients with gastric ulcer, typhoid fever and other conditions necessitating treatment in the recumbent position are often much troubled by their inability to eructate, and they often aggravate their discomfort, whether it is due to excessive gastric fermentation or not, by the aërophagy which results from their vain efforts to expel the gas. The explanation of this is that in the recumbent position the fundus is filled with food, the gas being present only in the superficial part of the body of the stomach. The œsophagus, therefore, enters the stomach at a point where it is filled with food, so that it is quite impossible to expel gas without first expelling a considerable amount of food. But in the erect position all the gas collects in the fundus; normally the cardiac orifice is situated just below the horizontal upper limit of the gastric contents, but as soon as any excess of gas is present in the stomach the upper limit becomes depressed, and gas can be expelled directly into the œsophagus. The patient should therefore be instructed to sit up when he feels that he would like to eructate; he should be told never to make an attempt whilst lying down. This is of great importance, as flatulent distention of the stomach delays the healing of a gastric ulcer, and aërophagy is almost invariably the cause of the flatulence in such cases.

One last warning I must give you. Many patients take aërated water for their flatulence. This of course acts in exactly the same way as aërophagy. It increases the amount of gas in the stomach, so that the patient eructates with ease, but what he brings up is not the supposed excess of gas to which he ascribed his discomfort, but simply the carbon-dioxide swallowed in the aërated water.

Appointments.

Civil.

LEVY, I., L.D.S., R.C.S. Eng., has been appointed Dental Surgeon to the North London Domestic Training Home for Girls.

SCALES, J. E., M.R.C.S., L.R.C.P. Lond., has been appointed Certifying Surgeon under the Factory and Workshop Act, for the Radstock District of the County of Somerset.

Guy's Romance.

THOMAS GUY never married. Had he done so, our hospital might never have been founded, and Guy's name, instead of becoming a household word, might have been remembered only by a few of antiquarian tastes as that of a benefactor of St. Thomas' and Christ's Hospitals in the 18th century. Of course it is possible that even had he married and left children, Guy might still have founded a great hospital with the bulk of his great fortune, after providing handsomely for his family. As it was, his bequests to relatives amounted to £63,000, mainly in sums of £1,000 in 4 per cent. Stock; every living relation seems to have been remembered, including even children of cousins to the third generation.

Among the few details we possess concerning Guy's life, there is only one incident which seems to hint that he ever contemplated marriage. That we will call "Guy's romance." But, unfortunately, it is of very doubtful authenticity; it is dismissed, indeed, in Wilks and Bettany's "History of Guy's Hospital," with the remark that "It is not worth while to speculate much on a story so destitute of authentication."

It is worth while to speculate a little. But, first, let us quote the story as it appears in John Nichols' "Literary Anecdotes of the Eighteenth Century":—

> "To show what great events spring from trivial causes, it may be observed, that the publick are indebted to a most trifling incident for the greatest part of his immense fortune's being applied to charitable uses. Mr. Guy had a maid-servant, whom he agreed to marry; and, preparatory to his nuptials, he had ordered the pavement before his door to be mended so far as to a particular stone which he marked. The maid, while her master was out, innocently looking on the paviours at work, saw a broken place they had not repaired, and mentioned it to them; but they told her that Mr. Guy had directed them not to go so far. 'Well!' says she, 'do you mend it; tell him I bade you, and I know he will not be angry.' It happened, however, that the poor girl presumed too much on her influence over her wary lover, with whom the charge of a few shillings extra-ordinary turned the scale entirely against her; for Guy, enraged to find his orders exceeded, renounced the matrimonial scheme, and built hospitals in his old age."

Nichols, unfortunately, does not state at what period in Guy's life the incident is supposed to have occurred; and, worse, he does not give his authority for the story. He does not even state whether he had it on hearsay. Such a tale

might easily be the invention of some calumnious tongue, and there are other anecdotes about Guy, showing him in the meanest light as a miser and sweater, which were probably invented by persons anxious to prove him such. The half-insane John Dunton was conspicuous in this invidious work.* Dunton, whose book was published in 1728, does not mention Nichols' anecdote of the maid-servant.

Nichols, however, is not the only author who relates the tale, and apparently not even the earliest. His "Literary Anecdotes" were published in 1812–15. Anthony Highmore's "Pietas Londinensis" was published in 1810, and he also mentions it. It will be observed that his account, which is worth quoting for this reason, is practically a paraphrase of Nichols', and in view of the dates of the two works was probably Nichols' source :—

> "The public are indebted to a trifling circumstance for the application of this fortune to charitable uses. He employed a female servant, whom he had agreed to marry. Some days previous to the intended ceremony he had ordered the pavement before his door to be mended up to a particular stone, which he had marked, and then left his house on business. This servant, in his absence, looking at the workmen, saw a broken stone beyond this mark which they had not repaired, and on pointing to it with that design they acquainted her that Mr. Guy had not ordered them to go so far. She, however, directed it to be done, adding, with the security incidental to her expectation of soon becoming his wife, 'Tell him I bid you, and he will not be angry.' But she soon learnt how fatal it is for anyone in a dependent situation to exceed the limits of their authority, for her master, on his return, was enraged at finding that they had stretched beyond his orders, renounced his engagement to his servant, and devoted his ample fortune to public charity."

None of the other authorities for Guy's life, including Maitland†, mention the story. It is quite possible, as Wilks and Bettany suggest, that there is a small modicum of truth in it, or it may have been fabricated or elaborated by a servant dismissed from Guy's service. A very trivial sordid tale it then becomes. On the other hand, Charles Knight ("Shadows of the Old Booksellers") liked to think the story true, and sentimentalised about it at length, adding a wealth of imaginary detail. Speaking of Guy, he says :—

> "He has once or twice conversed during the banquet at Guildhall with the daughter of a rich stationer, and has found her deplorably ignorant of the commodities in which her father deals. Gradually he begins to think that his own maid-servant is quite as attractive as a citizen's daughter; born of honest parents, religiously disposed, and skilled in cookery and other useful arts. What if this neat-handed Phyllis should become his wife! He is sure that he can compel her to regulate his affairs with due economy. She has never wasted money or victuals while in his service. She has professed that implicit obedience to his will which he requires. He at last makes his proposal, and is accepted graciously."

After telling the story of the maid's downfall as given above, he continues :—

> "The poor girl must accept her destiny, to remain unmarried to the thriving bookseller. The romance of Thomas Guy's life is over. He girds up his loins for a struggle for a plum. But if I see his shadow aright there is a soft place in his heart, where the memory of that ill-used woman will long abide."

Knight also attempts to find a matter-of-fact basis for the story in an order given in October, 1671, by the City Common Council for compelling tenants to pave the foot-pavements in front of their houses, six feet wide. At this time Guy was only 27 years of age, and had been but three years in business. His career as a philanthropist began some seven years later, so that, assuming the tale is true, and assuming that it belongs to the date suggested by Knight, it is quite possible that Guy's wealth might not have been directed into the channels of charity if his marriage had taken place at this time. In fine, it may be that a single paving-stone shattered Guy's romance (such as it was), and it may be that but for that same stone Guy's Hospital would never have had its foundation.

A. N. C.

* "An Essay on Death Bed Charity, exemplified in the life of Mr. Thomas Guy, late Bookseller in Lombard Street; . . . etc. Proving that great misers giving large donations to the poor in their last wills is no charity."

† The information in Maitland's "History of London (1739)" was evidently supplied by the hospital authorities, and it was therefore unlikely to contain the story.

Change of Address.

Lieutenant F. A. Barker, M.B., I.M.S., from Trichinopoly, S. India, to 96th Berar Infantry, Secunderabad, Deccan, India.

Surgeon D. A. Mitchell, R.N., from Guy's Hospital to Royal Naval Hospital, Haslar.

H. Gordon Spain, L.D.S. Eng., from Royal Marine Infirmary, Deal, to Royal Naval Barracks, Chatham, and from "Kildare," Gravesend, to "Clairville," Overcliffe, Gravesend.

F. J. Wheeler, M.R.C.S., L.R.C.P., from London to c/o Dr. E. Cronin Lowe, 31, Church Street, Southport, Lancs.

Vulcanite Dentures.

DENTAL
CLINICAL LECTURE BY MR. W. A. MAGGS.

GENTLEMEN,—Vulcanite being the material most commonly used in the construction of dentures, no apology is needed for bringing the subject before you. The base plate of a vulcanite upper denture should invariably be made of tin, either swaged or "struck-up." The old method of using wax for a base-plate should no longer be adopted; first, because a uniform thickness of vulcanite cannot be guaranteed—the strength of a plate is represented by its weakest point; and, secondly, because the rugæ cannot be properly reproduced.

The denture of former days, with its thick, smooth, and highly-polished lingual surface, is not to be compared for utility or comfort with the denture of to-day, with its uniform thickness, and its ridges corresponding to the rugæ of the palate. Formerly gold was more frequently preferred to vulcanite for a plate, chiefly, I think, because the gold was struck up to shape, but now that vulcanite dentures can be similarly constructed, they are far more acceptable to patients than gold, because they are lighter in weight and more adapted to suction.

The rugæ I need hardly say, are transverse folds of the mucous membrane of the palate, which serve a useful purpose in the disintegration of food, the tongue forcing and rasping the food against their rough surfaces. The plaster of Paris model should be reproduced in zinc, and the counter-die in lead, as if dealing with a metal plate. The tin base-plate, whether of one, or two, or three thicknesses, should correspond in all to about No. 19 gauge, and should be swaged in the "Differential Press," or "struck-up." A polishing-plate should invariably be used, and is best made by carefully burnishing tin-foil over the swaged base plate, the result after vulcanization being a well-polished denture. The maximum amount of suction is obtained by carrying the vulcanite as far back as possible on the hard palate. There is no fear of impinging upon the soft palate, and thereby defeating the end in view by the plate being dislodged during deglutition or speaking. The practical way of testing the matter is to place the denture in position in the mouth, and look at the soft palate while the patient is talking; it will be seen that the distal margin of the denture is invariably well in front of the soft palate. It often happens that want of suction is due to the vulcanite plate having been made too short; therefore it is the safest course in every case to carry the vulcanite well backwards, and to cut it away if it is not comfortably tolerated or causes nausea. In my early days of practice small plates—so dear to lady patients—seemed to me to be the ideal, but later their instability and the danger of their being swallowed caused me to discard them; I also found that they required bands, whereas large plates do not; and, further, that with large plates the resonance of the voice is improved, as has been verified by the statements of patients who are singers or public speakers. The use of bands, and still more the use of wires, should whenever possible be avoided, for as everyone knows clasps of every description cause decay by harbouring decomposing food and by friction.

Bands may be needed in dentures for patients whose remaining natural teeth are loose, and also in the case of those who resort to dentures late in life.

Bands are more frequently required in a lower denture than in an upper, on account of the action of the tongue, which tends to dislodge a lower plate. It is my custom to use perforated gold plate, dental gauge No. 5, in upper vulcanite dentures (excepting in some full plates, in which thick vulcanite extends round the labial surfaces) struck up and imbedded in the vulcanite, so that it neither shows on the palatal nor on the lingual surface of the finished denture. The perforated gold, whilst it adds materially to the toughness of a plate, does not thicken it, but in the combination the advantages of the *suction* of a vulcanite and much of the *strength* of a gold plate are secured. The perforated gold should always be carried over the alveolar ridge, because it is here that the strain is greatest.

A lower vulcanite denture should be strengthened by having a flattened and roughened gold wire embedded in it, and if bands be necessary they should be soldered to the wire. Provided the ridge of an edentulous mandible be large and round, and protected by thick gum, the denture should be lined with gold plate, and the vulcanite attached to it by means of retaining "tags."

A sharp ridge of bone, and a thin mucous membrane contra-indicate a gold lining, as the gold cannot be eased so freely as vulcanite.

A full upper denture should extend over the tuberosities on both halves of the maxilla; suction is thereby increased, and the forward movement of the plate prevented. The vulcanite should be cut away at the point of insertion

of the buccinator muscle, which corresponds on each side to the site of the first permanent molar, and at the middle line in front, corresponding to the fold of mucous membrane of the lip known as the "frænum."

A full lower denture should extend well down on both sides at the posterior lingual surface—often called by mechanics, for some inscrutable reason, "the heel"—because the plate is unaffected by muscular action at this point, and, as in an upper denture, it should be cut away for the buccinator muscles and the frænum.

A good practical way of determining whether a lower plate is too deep is to pull upwards the lip and cheek of the patient, and should any muscle move the denture it is an indication that the plate is too low at that place.

When suction fails with the ordinary plate, the use of the "Fulsome ridge" is advocated. This ridge is made by cutting a groove on each side of the palatal surface of the plaster model, about one-third of an inch from the alveolar border—the thickest part of the mucous membrane—and another groove at the distal surface of the palate. The vulcanite runs into these artificial grooves, and the suction is thereby improved.

A better plan, in my opinion, is to make use of what is known as a "suction plate," which is made of aluminium, dental alloy, or gold, in various shapes and patterns. Such a plate is worn on the finished denture in contact with the palate. I have found the "cup suction plate" most successful in difficult cases, such as flat palates with thin mucous membrane and in underhung bites, the cohesion being much improved, and in many cases entirely satisfactory.

I am not an advocate of rubber suction discs. They are troublesome in that frequent renewal is necessary, and sooner or later cause discomfort and inflammation. They give stability to a new denture, but the same may be said of powdered gum tragacanth, and a closely-fitting upper denture with vulcanite around the labial surface really acts as a "sucker."

"Gum sections" are admirably adapted for full dentures, and if the sections are closely fitted a natural appearance is produced, which is pleasing to the eye. Their chief charm, I think, consists in the spacing which exists in all "gum sections," and if more care were exercised in this respect in the construction of vulcanite dentures, such dentures, well-polished, could be made to look equally pleasing. In speaking of spacing artificial teeth I may say that the centrals should not be spaced, otherwise there is a likelihood of hissing in speaking, but the other teeth should be set slightly apart, and not in juxtaposition, like the arrangement of pianoforte keys, as is too often seen.

Other points in the arrangement of the teeth are these:—the posterior upper molars on both sides should be on a higher level than the other teeth, and artificial teeth should always be placed above the mid-alveolar ridges, and not outside them. In elderly persons who have been long edentulous the jaw-bones become much wasted, the consequence being that the superior surface of the mandible is very flat, having little or no ridge of bone. In such cases it is difficult for a lower denture to be kept in position during eating and drinking, and a weighted plate is a great help. To make such a plate a suitable bar of solid tin is embedded in the vulcanite, care being taken that the metal does not impinge upon the base of the vulcanite, where it might be badly tolerated, or on the labial surface, where it would be unsightly. The extra weight is occasionally objected to, but the chief disadvantage is the liability to breakage, should the denture fall out of the hands of the patient.

Spiral springs may be adopted as a last resource, should a weighted lower be unsatisfactory. Whilst not advocating springs unless necessary, I consider they are often undeservedly condemned, for they prevent dislodgment of the plates, and make speaking and eating easy and comfortable. It is true that food collects around the springs, that they wear out in the course of one or two years, and that they may be broken, usually from kinking in putting the dentures in the mouth, but their use for aged persons adds so much to the stability of the dentures as to outweigh by far their disadvantages. The proper position of the screws for the springs is important. They should be placed in the lower denture between the second premolar and the first molar, and slightly anterior to this position in the upper denture. The swivels should be parallel to each other when the dentures are articulated. Gold washers should be used, and in lower plates the washers should be turned up posteriorly for the purpose of making a stop for preventing the springs working downwards and cutting into the mucous membrane of the jaw. It is well not to use longer springs than are necessary, for not only is their strength thereby diminished, but the mucous membrane of the cheek is liable to be cut, and much pain and discomfort caused. It is easy to determine the right length of springs by seeing that they are *slightly* flexed posteriorly, when the dentures are in

position, and the mouth is opened to its full extent.

To summarise, I would reiterate and emphasize the following points :—

That swaged or "struck-up" base plates and polishing plates are essential for upper dentures.

That the vulcanite should cover the tuberosities of the jaw, and as much of the hard palate as the patient can tolerate.

That clasps of all kinds should as far as possible be avoided.

That "the Fulsome ridge," "the cup suction plate," the weighted lower denture and spiral springs have their uses.

Appointments.

Naval and Military.

Fleet Surgeon ROBLEY BROWNE, R.N., has been appointed Senior Medical Officer, Royal Naval Training Establishment, Shotley, Harwich.

Surgeon A. W. IREDELL, R.N., has been appointed to the *Bulwark*.

Captain H. O. M. BEADNELL, R.A.M.C., has been granted six months' leave home from India.

Colonel P. A. WEIR, M.A., M.B., I.M.S., Inspector General of Civil Hospitals, Central Provinces, has been granted privilege leave for one month and five days.

During the absence on leave of Lieutenant-Colonel CHILDE, M.B. Lond., I.M.S., Lieut.-Colonel C. H. L. MEYER, M.D. Lond., acts as Professor of Medicine, Bombay.

Captain P. K. TARAPORE, I.M.S., has joined the Jail Department, Burma.

Lieutenant F. A. BARKER, M.B., I.M.S., has been posted to the 96th Berar Infantry, Secunderabad, India.

Major OSWALD J. CURRIE, M.B., late Natal Field Artillery, has been appointed to the command of B Company, Cape Medical Corps.

Specialities.

A New Anatomical Model.

THE GRESHAM PUBLISHING COMPANY, of 34 & 35, Southampton Street, W.C., have recently sent for our inspection their new anatomical model, which is a life-size reproduction of dissections of the various parts of the female human body. The model consists of a series of cunningly superimposed plates, each of which can be "reflected"—to use the term beloved of anatomists—so as to show in succession all the layers of the body, from the skin to the skeleton. The model is accompanied by a descriptive index by Mr. Frederick Norman, F.R.C.S., and Dr. W. G. Stone, F.R.C.S. It is designed to be of service to the student who is acquiring his knowledge of anatomy; to the practitioner who wishes to revise his knowledge as rapidly as may be; and to nurses, masseuses and midwives, to take the place of dissection and the inspection of actual specimens. For the benefit of midwives, a model of the different stages of pregnancy, which can be attached to the larger model, has been devised. This shows the condition of the uterus and its contents from the earliest weeks of pregnancy to the interval before the third stage of labour.

It is obvious, of course, that the model can in no way take the place of actual dissection for medical students, but for purposes of revision, and for those who, while needing a knowledge of anatomy, have not the time or the opportunity to acquire that knowledge by the one scientific method of dissection, it should prove invaluable. It is a little difficult to anyone who has worked in a dissecting-room to realise the immense disadvantage those who have not enjoyed that privilege must labour under. A life-size model such as the one under notice is the second best method of studying anatomy.

A Useful Catalogue.

Messrs. STOKES & Co., LTD., of 74, Cornhill, E.C., are well known as a high-class firm of sports and athletic outfitters. They have recently issued a new catalogue of requisites for cricket, golf, tennis, croquet, and other summer sports. A separate catalogue is published for winter sports, and either of these will be sent post-free on application. Messrs. Stokes also make a speciality of club colours, and are the appointed outfitters to a large number of clubs in connection with Government departments, City firms, etc. The prices quoted in the catalogue are in all cases reasonable, but it should be noted that they are subject to market fluctuations, and in the case of tennis and golf balls, of course, there have been recent advances.

"Sleep, Sleep no more!"

In bygone days when roused from out my sleep
By the desire, and Witson's knocks repeated,
The needful toll of "9 o'clock's" to keep,
So that my "signing-up" might be completed,
The thought which kept me from complete despair
Was, that I soon should sleep when I got there.

But now no more against the restful wall
Can I resume my interrupted slumber.
This term I haven't slept at one at all,
Although I have attended quite a number,
Because abusive workmen overhead
Hammer as if they would arouse the dead.

So I complain 'tis really hardly fair
To make a man attend an early lecture,
And then prevent his sleep when once he's there
By noisily-conducted architecture,
And I suggest, until repairs are ended,
All lectures should be taken as attended.

A. NUTT.

Sport.

Guy's Athletic Sports.

The Annual Sports were held at Honor Oak Park on Saturday, June 4th. The proceedings were considerably marred by the rain which fell at intervals, but despite this fact some excellent racing was witnessed by a fair gathering of spectators. Some of the finishes were close indeed, that between Fry and Barraclough in the mile being so close that the judges were unable to separate them. Several promising runners among the freshmen were discovered, and the chances of the club in the Inter-Hospital Sports seem particularly rosy. A. L. Stokes is to be congratulated on winning the Lucas Cup for the second year in succession.

In the unavoidable absence of the President, Dr. Fawcett, Mr. Lane was asked to introduce Mrs. Hughes, and this he readily agreed to do.

The thanks of the committee are due to Mrs. Hughes for so kindly distributing the prizes, to Mr. Lane for the ready assistance he gave, to Messrs. P. Turner, E. C. Hughes, W. M. Mollison, T. G. Stevens, Dr. H. C. Cameron and Dr. L. Stokes for the untiring and painstaking manner in which they carried out their part of the proceedings, and to Dr. French for kindly presenting the prizes for the Tug-of-War.

A list of results is appended :—

100 YARDS.—H. W. Evans 1, A. L. Stokes 2, A. B. Danby 3, C. H. Medlock 4; 2 yards: 10$\frac{1}{5}$ sec.

PUTTING THE WEIGHT (SCRATCH AND HANDICAP).—Scratch: A. L. Stokes, 34ft. 4in., 1; A. Moberly, 30.11, 2; W. G. Tucker, 23.8, 3. Handicap: A. Moberly, 3.6, 34.5, 1; A. L. Stokes, scratch, 34.4, 2; R. G. Oram, 3.0, 3.

880 YARDS HANDICAP.—W. K. Fry, scratch, 1; A. P. L. Johnson, 35 yards, 2; C. H. Gould, 60, 3; 5 yards, 2 yards; 2 min. 8$\frac{4}{5}$ secs.

100 YARDS HANDICAP.—A. B. Danby, 3$\frac{1}{2}$ yards, 1; E. A. Levisseur, 8, 2; H. W. Evans, scratch, †; C. H. Medlock, 4, †; $\frac{1}{2}$ yard, inches; 10$\frac{1}{5}$ secs.

HIGH JUMP (SCRATCH AND HANDICAP).—Scratch: W. H. A. Pratt, 5ft. 0$\frac{1}{2}$in., 1; R. G. Oram, 4.11$\frac{3}{4}$, †; J. B. Hance, 4.11$\frac{3}{4}$, †; C. H. Medlock, 4.11$\frac{3}{4}$, †. Handicap: C. H. Medlock, rec. 3$\frac{1}{2}$in., 5.3$\frac{1}{4}$, 1; J. B. Hance, 3, 5.2$\frac{3}{4}$, 2; W. H. A. Pratt, 1, 5.1$\frac{1}{4}$, 3.

440 YARDS HANDICAP.—J. H. Griffen, 8 yards, 1; A. B. Danby, scratch, 2; R. C. Matson, 10, 3; W. K. MacKay, 15, 4; $\frac{1}{2}$ yard, 3 yards; 53$\frac{3}{5}$ secs.

120 YARDS HURDLES.—H. F. Renton 1, A. L. Stokes 2, W. J. O'Kane 3; yard, 5 yards; 17 secs.

MILE.—J. R. Barraclough †, W. K. Fry †, H. Parry-Price 3; dead heat, 10 yards; 4 min. 47$\frac{1}{5}$ secs.

THROWING THE HAMMER (SCRATCH AND HANDICAP).—Scratch: W. G. Tucker, 102ft. 11in., 1; R. G. Oram, 85.0, 2; V. A. Levisseur, 43.5, 3. Handicap: R. G. Oram, rec. 20ft., 105.0, 1; W. G. Tucker, scratch, 102.11, 2; V. A. Levisseur, rec. 35, 78.5, 3.

220 YARDS HANDICAP.—J. H. Griffen, 8 yards, 1; A. R. Danby, 2, 2; H. W. Evans, scratch, 3; 3 yards, 4 yards; 19 secs.

LONG JUMP (SCRATCH AND HANDICAP).—Scratch: B. Sampson, 19ft. 5$\frac{1}{2}$in., 1; W. R. Gwynn-Davies, 18, 2; J. B. Hance, 17.9$\frac{1}{2}$, 3. Handicap: W. R. Gwynn-Davies, rec. 3.6, 21ft. 6in., 1; J. B. Hance, 3.6, 21.3$\frac{1}{2}$, 2; E. A. Levisseur, 4, 19.10, 3.

440 YARDS HANDICAP (College, Medical School and Works Department).—Hanson, 25 yards, 1; Wells, 30, 2; easily; 57$\frac{3}{5}$ secs.

120 YARDS HURDLES.—H. F. Renton, owes 15 yards, 1; W. J. O'Kane, 10, 2; E. A. Levisseur, scratch, 3; yard, 8 yards; 19 secs.

THREE MILES HANDICAP.—J. R. Barraclough, 50 yards, 1; A. P. L. Johnson, 250, 2; W. G. Fry, scratch, 0; 5 yards; 16 min. 15 sec.

TUG-OF-WAR.—Old Crocks beat Third Year Men, 2–0.

220 YARDS RACE.—H. W. Evans 1, A. L. Stokes 2, J. H. Griffen 3, E. S. Bowes 4; inches, 10 yards; 23$\frac{3}{5}$ secs.

440 YARDS SCRATCH.—A. B. Danby 1, E. S. Bowes 2, W. J. O'Kane 3.

880 YARDS SCRATCH.—C. H. Greene 1, W. K. Fry 2, C. H. Gould 3.

ONE MILE HANDICAP.—J. Barraclough 1, A. P. L. Johnson 2.

THREE MILES SCRATCH.—W. K. Fry 1, J. R. Barraclough 2.

DONKEY RACE.—H. J. Levisseur 1.

Cricket.

GUY'S v. GRANVILLE (LEE).

Played at Honor Oak Park on Wednesday, May 25th. Guy's won the toss, and went in first on a good wicket. After Munden and Blackwood had been dismissed for 26 runs, Montgomery and Birks stayed together, and playing good cricket took the score to 163 before being separated. Guy's eventually declared with the score at 300 for eight wickets. The Granville were dismissed for 174, and only H. Smith offered any prolonged resistance. He batted well for 61, but gave two chances.

GUY'S.

M. M. Munden, c Cockell, b Johnston	2
R. Montgomery, st Cockell, b Smith	107
B. Blackwood, lbw, b Johnston	9
A. H. Birks, b Young	77
W. E. S. Digby, lbw, b Johnston	6
A. F. Rook, c Smith, b Young...	10
R. M. Veale, c Cockell, b Young	21
F. C. Hunôt, b Young	12
R. S. Kennedy, not out	28
A. H. Harkness, not out	8
Extras	20
Total (for 8 wickets)*	300

J. E. Rhys Evans did not bat.

* Innings declared closed.

GRANVILLE (LEE).

J. A. Gravitt, b Kennedy	1
H. Smith, b Blackwood	61
C. Helder, c Birks, b Kennedy	8
F. E. Lander, b Montgomery	16
A. S. Johnston, b Rook	6
N. Cockell, b Blackwood	17
P. P. Lincoln, c Digby, b Rhys Evans	10
C. O. Kenyon, b Rhys Evans	0
C G. Young, b Blackwood	17
D. D. Steven, b Blackwood	5
Brown, not out	4
Extras	29
Total	174

GUY'S v. BEXLEY ASYLUM.

Played at Bexley on May 28th. Guy's won the toss, and went in first. Montgomery and Birks again batted very well, scoring 46 and 45 respectively, and at one time a big score seemed likely. However, after the dismissal of Birks and Montgomery wickets fell rapidly, and Guy's were all out for 160. On Bexley going in Montgomery bowled with deadly effect, securing seven wickets for 27 runs, the side being dismissed for 60.

GUY'S.

M. M. Munden, b Everest	9
R. Montgomery, lbw, b Goddard	46
A. H. Birks, b Goddard	45
A. H. Harkness, b Pace	7
F. C. Hunôt, b Goddard	0
R. M. Veale, b Pace	7
B. Sampson, c Goddard, b Everest	19
A. F. Rook, b Pace	4
E. S. Bowes, c Mitchell, b Pace	12
C. E. Rice, not out	3
J. E. Rhys Evans, c Goddard, b Everest	0
Extras	8
Total	160

BEXLEY ASYLUM.

H. B. Goddard, c and b Rook	8
Dr. Bartlett, c Rice, b Montgomery	9
H. Mitchell, b Montgomery	0
C. Keenan, c Evans, b Montgomery	14
A. Joliffe, b Montgomery	1
G. Everest, b Montgomery	0
Dr. Evans, c and b Montgomery	12
Lunn, b Rook	1
Pace, b Rook	4
Williams, not out	4
Rolfe, c Munden, b Montgomery	5
Extras	2
Total	60

Lawn Tennis.

GUY'S 1ST VI. v. DULWICH FARM.

This match was played at Honor Oak Park on Saturday, May 28th, when the hospital were defeated by eight matches to one. Result:—

R. Curle and H. W. Barber lost to J. P. May and T. D. Philpot, 3–6, 4–6; lost to V. Penman and Courtin, 4–6, 8–6, 5–7; lost to Taylor and R. Brydone, 4–6, 4–6.

G. C. Covell and G. H. Hunt beat Penman and Courtin, 6–2, 13–11; lost to May and Philpot, 5–7, 1–6; lost to Taylor and Brydone, 1–6, 3–6.

L. Price Harris and H. S. Groves lost to Taylor and Brydone, 1–6, 4–6; lost to Penman and Courtin, 3–6, 2–6; lost to May and Philpot, 1–6, 1–6.

GUY'S 1ST VI. v. SURBITON.

This match was commenced at Honor Oak Park on Saturday, June 4th, but had to be abandoned on account of the weather during the first round.

GUY'S 2ND VI. v. CHISWICK AND WEST LONDON.

This match was played at Chiswick on Saturday, June 4th, and resulted in an easy victory for the hospital by eight matches to one. Result:—

H. S. Groves and L. Price Harris beat Sharp and Dobson, 6–4, 9–7; beat Dr. Atkinson and Jarvis, 6–2, 6–2; beat Copps and Orries, 6–1, 6–4.

E. P. Poulton and G. W. King beat Atkinson and Jarvis, 8–6, 6–3; beat Sharp and Dobson, 6–0, 10–8; beat Copps and Orries, 6–1, 6–4.

R. Farrington and C. Billing lost to Copps and Orries, 1–6, 5–7; beat Atkinson and Jarvis, 5–7, 6–3, 6–2; beat Sharp and Dobson, 6–3, 6–2.

The Inter-Hospital Senior Cup Ties will take place at Chiswick Park on June 27th, 28th, 29th.

Hockey.

Season, 1909—1910.

At a meeting of the Hockey Club held at the beginning of the season the following officers were elected:—President, Mr. F. J. Steward, M.S.; Captain, G. Y. Thomson; Vice-Captain, L. Bromley; Hon. Secretary, F. A. Dick.

Looking back at the season as a whole, the team has been most successful, winning the Inter-hospital Tournament for the fourth year in succession. Many of the matches early in the season were lost, but that was largely due to the fact that it is difficult to put a team of full strength into the field on a Wednesday afternoon.

In the Inter-hospital Tournament the team was the same as that which played the season before, but this year considerable improvement was shown, especially among the forward line, which was rearranged. Birks was played outside right, Camp inside right, and Bromley inside left. The right wing combined well together, and Camp showed considerable power of shooting. Bromley played a vigorous game, and it was evident that his new position suited him far better than his last year's position of inside right.

On the whole, it may be stated that whereas last season the forward play was distinctly of a scrambling

hit and rush character, this year the passing was more accurate, and occasionally some really fine combined play took place. Pern, in goal, was safe, and also played well at back on occasions. The backs, Duke and Archer, maintained their reputation for hard hitting and sturdy defence, while the halves hit the ball cleanly and showed that they had got over the inclination to turn on the ball, which was an occasional feature of the last season.

The first inter-hospital match was played against St. Thomas's on the Brondesbury ground, which was not in very good condition, and ended in a comparatively easy win for Guy's by 5 goals to 2. The next match against St. Bartholomew's was played on the Mid-Surrey ground at Richmond, and also resulted in an easy win by 7 goals to nothing. The final match was played against the London Hospital on the same ground, which was rather hard, and the ball rose dangerously at times. Birks and Dick were not playing, and were badly missed at outside. The forward play was disappointingly ineffective in consequence. At the beginning of the second half, one of the London forwards received a blow on the forehead from the ball, which fortunately was not of much consequence, and he continued to play. Towards the end Bromley was hit over the eye with the ball, and for the rest of the match he could only see with one eye. The result was a draw, two goals all. This match was replayed on the Brondesbury ground. The London had practically the same side, while Guy's this time were at full strength. It resulted in a win for Guy's by 6 goals to 3, after the score had been 3 goals all at half time.

It was much to be regretted that Mr. Fagge, who has on many occasions watched the tournament games, spent a large part of the afternoon in motoring about Ealing trying to find the ground, which nobody appeared to know.

After the match Mr. Steward kindly entertained the Guy's team to dinner at the Trocadero. Mr. Steward showed himself to be an ideal host, and his store of anecdotes of the old hospital days were particularly interesting, and kept his hearers' attention fixed until towards midnight. After the captain had proposed Mr. Steward's health, it was given out that the speaking was to be of an informal nature, and so, as no reporters were present, it is unfortunately lost to posterity.

Towards the close of the evening there were loud cries of "Mr. Dick," who, after considerable persuasion, got up and delivered a speech of quite remarkable brevity, in which he proposed a vote of thanks to Mr. and Mrs. Steward for their interest in the doings of the club. And so ended an evening which will not be forgotten readily by any of those who had the pleasure of taking part in it.

At present, we understand negotiations are in progress for the regular hiring of a ground for next season. So far the club has been under the disadvantage of being obliged to play all its matches away from home, and it is hoped that by the new arrangement a large number of men who at present take no regular exercise, will be induced to play. At the same time it is to be pointed out that the success of the scheme depends entirely on there being a sufficient number of men who have the time and the interest to play with regularity throughout the season, and this ought to be the case considering the present popularity of the game in England. The team was as follows:—

F. A. Dick, L. Bromley, E. P. Poulton, A. F. Camp, A. Birks (forwards); W. T. Clarke, F. Kahlenberg, G. Y. Thomson (halves); H. L. Duke, H. Archer (backs); M. Pern (goal).

Guy's Hospital Swimming Club.

Swimming.

The season started very successfully, the Club's representative four defeating the London Hospital in the final. The Inter-Hospital team race, postponed from 1909, was won by three yards. Team and times:—

GUY'S.—York-Moore, 42·3 sec.; Glover, 44 sec.; Pern, 45 sec.; Rhodes, 47 sec.

Water Polo.

GUY'S v. KINGSTON.

Played at Kingston, June 3rd. The result of this match, after an excellent game, was a draw, 2—2. Team:—

GUY'S.—Hance, Stewart, Pern, Moberly, Stradling, Glover, Holloway.

Birth.

MOLLISON.—On June 5th, at the Warden's House, Guy's Hospital, the wife of W. M. Mollison, M.A., M.C., of a daughter.

Marriages.

BALL—OTTLEY.—On June 2nd, at St. John's, Portland, by the Vicar, the Rev. T. A. Ottley, D.D., father of the bride, assisted by the Rev. E. Ottley, brother of the bride, and the Rev. J. Butler, Malcolm Edward Ball, M.B., B.S. Lond., of Emsworth, Hants, third son of Edward Ball, J.P., of Blackheath, to Evelyn Irene, youngest daughter of the Rev. Dr. Ottley, of Portland, Dorset.

HENDERSON - BAKER.—On June 2nd, at St. Peter's Church, Brockley, by the Rev. C. H. Grundy, Hal J. Henderson, M.B., B.S. Lond., of the Red House, Amersham, Bucks, to Anita R. Baker, of 15, Park Road, Bexhill-on-Sea. At home—Thursdays, July 21st and 28th, 1910.

Death.

SHARP.—June 6th, at Fishpond Drive, Nottingham, aged 42, Arthur John Sharp, M.D. Lond., F.R.C.S. Eng., younger son of the Rev. J. Sharp, B.F.B.S.

E.—A. N. C.

GUY'S HOSPITAL GAZETTE.

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Passim.

WE heartily congratulate Mr. T. D. M. Stout and Mr. H. Gardiner, who have won the Treasurer's Gold Medals in Clinical Medicine and Surgery respectively.

THE Hilton Prize for Dissections has been divided between Messrs. W. L. Webb, S. Keith, and J. F. G. Richards.

THE following appointments have been made by the House Committee on the recommendation of the Medical Committee:—House Physicians, H. L. Attwater (Dr. Pitt), A. L. Fitzmaurice (Dr. Shaw); House Surgeons, C. H. Mills (Mr. Lane), J. L. Johnston (Mr. Dunn); Out-Patient Officers, L. Bromley, E. L. Elliott, R. C. H. Francis, V. T. P. Webster; Assistant House Surgeons, J. G. Saner (Mr. Steward), F. Kahlenberg (Mr. Fagge), G. H. Peall (Mr. Rowlands), N. A. D. Sharp (Mr. Turner); Obstetric Resident, F. S. D. Berry.

THE following appointments have been made by the House Committee on the recommendation of the Dental Council:—Dental House-Surgeons, N. Edgar, A. J. Reynolds, A. L. Saul; Assistant Dental House-Surgeons, H. Elwood, F. W. Paul, C. H. G. Penny.

AT the Annual Meeting of the Royal Society of Medicine, held on July 1st, at 5 p.m., Sir Henry Morris will be proposed by the Council for election to the office of President, in succession to Sir William Church.

THE Medical and Engineer units of the Officers' Training Corps are this year going into camp at Aldershot for a fortnight's training from July 30th to August 13th. So far as the medical unit is concerned an excellent course of instruction may be anticipated. Equipment for two complete sections of a field ambulance will be in use during the whole fortnight, including twelve waggons and two water carts. This year the cadets themselves are to furnish drivers for these carts. The Field Ambulance will be in command of Major Herringham, with Colonel James as instructor. It is a matter of great disappointment to all concerned that Captain Davies-Colley cannot get away from his duties at the Hospital during that fortnight. This will make the "B" section from Guy's and St. Thomas's short of one officer, and this will be

felt all the more as Lieut. Layton is acting as Quartermaster to the Camp, and cannot give so much time to the company work. Our men are going, however, with the intention of being much the smartest section in the camp, and this, with the efficiency of Sergts. Robinson, Rook, Gatley, Cowtan, and Campion, will make up for the shortage of officers. One of the most pleasant memories of last year's camp was the good-fellowship between the men of the two hospitals working together in the one section. It is greatly to be hoped that everyone who possibly can will go for the whole fortnight. The two consecutive weeks of training are worth at least three times that of the isolated week.

DR. FAWCETT, the hard-worked secretary of the Biennial Dinner, informs us that he can receive applications for tickets up to the last post to-day, so that there is still just time for any old Guy's man who has not yet signified his intention of attending the dinner to do so. On another page we publish a list of those who have already taken tickets. This list is a sufficient indication, confirmed by the other signs, however, that this year's dinner will be a very successful and enjoyable function.

A FEW weeks ago we published in these pages an account, extracted from the *Lancet*, of a Guy's dinner in the old days, showing what the Biennial Dinner will not be like. In reading Mr. Morris's recently-published and very entertaining "History of the London Hospital," we came across an account of that hospital's old festival dinners, which similarly reflects the strange manners and customs of a bygone age:—

> The ponderous meal began at five o'clock, but the stewards "were not expected to pay for wines drunk after midnight." Up to midnight, however, all were welcome and were expected to drink heartily, and it is recorded that "the stewards decided to cover the tables with Port wines, that Madeira and Sherry be distributed discretionally, but Claret be only at the upper table." Strong beer was provided *ad libitum*. Two "careful persons" were to be procured, "to take care of the wine, one in the dinner-room to receive it, and one at the door to prevent its being carried away." This precaution was probably necessary, because the guests brought their own servants to wait on them, and these were provided with a dinner and one pint of wine each. At the later festivals this custom was put an end to, on account of the expense to the stewards, who themselves found servants to do the waiting. It had been found that many persons joined the procession on its march through the City, and got in to the dinner on the plea of being somebody's servant.

IT seems that there is an organisation known as the Egyptian Society in England, to which some of our students (the Oriental variety of the species, "irresponsible junior," no doubt) belong. This Society has suddenly sprung into an undeserved notoriety through a half-column of interview with one of its members, a Mr. Selim, which recently appeared in the *Daily Express*. It appears that the Society was quite annoyed by Mr. Roosevelt's Guildhall speech, and told him so in a telegram. No harm was done to anybody, you see; but then the *Express* came along and made a scare paragraph about the matter, implying that the Society was a menace to British control in Egypt, and that it had insulted the wielder of the "big stick." However, the objects of the Society, as stated in the interview, were of the most harmless and worthy character, the only suspicious features being that the meetings were said to be held in Arabic and a Bloomsbury Hotel. A remarkable sequel to the discussion aroused by this interview is that we have received letters, which will be found in our correspondence column, from two gentlemen protesting that they are *not* members of the Society. We have printed these letters in the belief that, in spite of the apparent unimportance of this information to the world at large, their authors must attach some importance to it. But we cannot encourage this form of correspondence. We, personally, are non-members of many societies, but we do not trouble our readers with the information. For all we know there may be a Welsh Society in England, holding its meetings in Welsh, even in a "Bloomsbury Hotel," but we do not want Mr. Lloyd-Jones and Mr. Evans-George to write saying they are not members.

The Mortality of the Operative Treatment of Chronic Intestinal Stasis during the year June, 1909, to June, 1910, at Guy's Hospital.

In view of the interest that is taken in the subject of Chronic Constipation, it was thought that the following facts might be worth recording. In the list given below, in brief, only those cases have been included which were treated for the above condition by Lateral Anastomosis or Colectomy. In all, 15 patients have, during the time stated, been subjected to surgical treatment, and there has been one death, and that was due to the bursting of an abscess in the abdominal wall into the general peritoneal cavity, on the seventh day after the operation.

CASE 1.—E. G., æt. 25. Marked constipation for seven years. Had been treated at Charing Cross and London Hospitals for constipation. No improvement. Had done no work for eighteen months because of abdominal pain and sickness. Lost 21 lbs. weight in 18 months. Vomits after most meals: hæmatemesis on few occasions. Colectomy. Recovery.

CASE 2.—G. C., æt. 25. Constipation marked for seven years. October, 1905, appendix removed. March, 1906, laparotomy for perforated gastric ulcer: none found. Unaided by medicine, constipation for seven to fourteen days. Not much pain. Colectomy. Death. Abscess in abdominal wall burst into general peritoneal cavity on the seventh day. General peritonitis.

CASE 3.—D. C., æt. 20. Constipation sixteen years; much abdominal pain. July, 1908: Mr. C. freed sigmoid from adhesions; removed right ovary. 1909: Mr. C. again opened abdomen for pain. 23rd July, 1909: lateral anastomosis; felt very much better except for attacks of abdominal distension and pain. February, 1910: Colectomy. Recovery.

CASE 4.—E. B., æt. 40, admitted for abdominal pain, loss of weight. Previously treated in medical wards for ? gall stones, ? floating kidney, ? general enteroptosis. Colectomy. Recovery.

CASE 5.—H. T., æt. 31, admitted for abdominal pain and general weakness. August, 1898: Nephrorrhaphy. January, 1900: Nephrorrhaphy. April, 1901: Marked abdominal pain. Laparotomy. Nothing found. 2nd July, 1909: Depression, headache. Invalid for seven years. Pain in the left iliac fossa. Marked constipation seventeen years. 17th July, 1909: Colectomy. Recovery.

CASE 6.—F. M., æt. 32. October, 1908, admitted under Dr. Shaw for constipation of five years' standing. January, 1904: Laparotomy in St. Thomas's. No cause for obstruction found. July, 1904: Laparotomy in St. Mary's. Again no cause found. Later again in St. Mary's, treated medically, six motions in five weeks. Laparotomy by Mr. Fagge. Adhesions broken down. Short relief. Readmitted to Guy's 10th August, 1909, having had two more acute attacks. Bowels not opened for nine days after admission. X-rayed with Bi. Obstruction observed in small intestine. On 30th transferred to surgical wards after eleven days' obstruction. 31st August, 1909: Colectomy. 13th October, 1909: Laparotomy. Intestines found matted down with inflammatory adhesions. 1st December, 1909: Abdomen again opened. Fæcal fistula opened. Still in hospital.

CASE 7.—Nurse A. S., admitted for abdominal pain. Three and a half years' marked constipation. Treated medically for two years by Dr. P. No effect; symptoms worse; melancholic at times. September 13th, 1909: colectomy; recovery.

CASE 8.—A. B., æt. 51, admitted December 1st, 1909, for marked abdominal pain. December, 1906: Left ovary removed; no improvement. November, 1907: Anal fissure diagnosed and sphincter stretched. No relief. Constipated all her life. December 9th, 1909: Lateral anastomosis. Recovery.

CASE 9.—E. B., æt. 29. Admitted 16th November, 1909, for abdominal pain and constipation. Always been somewhat constipated; worse lately. Incapacitated from work since March, 1909. Marked retching, vomits at times. Pain worse after food. November, 1909: Lateral anastomosis.

CASE 10.—L. W., æt. 40. Admitted for pain in right iliac fossa. 1904: Hysteropexy; left ovary removed. 1905: Operation for hæmorrhoids. 1906: Coccyx partly removed for pain; left nephrorrhaphy. 1907: Right nephrorrhaphy. Abdominal pain for ten years. Constipation all her life, rarely relieved by purgatives. 8th November, 1909: Colectomy. Recovery.

CASE 11.—E. D., æt. 18. Constipation fifteen months. On admission found to have ulcers of legs, diagnosed as secondary syphilis. Discharged. Re-admitted January 26th, 1910. Purgatives useless. Bowels opened by enemata with difficulty; had been twenty-eight days without action of bowels. Headache, vomiting. March 11th, colectomy. Recovery.

CASE 12.—E. W., æt. 35. Constipation and abdominal pain since childhood. Vomiting and abdominal distension. Wasting. Appendicectomy August 31st, 1908. February 3rd, 1910, lateral anastomosis of ileum to sigmoid. Recovery.

CASE 13.—N. B., æt. 19. Constipated ever since she can remember. Purgatives useless. Relief by enemata with difficulty; sometimes bowels confined for three weeks. Headaches and abdominal pain. Has lost flesh and cannot work. February 24th, 1910, colectomy. Recovery.

CASE 14.—Miss R., æt. 34. Lateral anastomosis four years ago. Colectomy, November, 1909. Recovery.

CASE 15.—Miss C., æt. 31. Resection of part of sigmoid four years ago. May 17th, 1910, lateral anastomosis. Recovery.

H. R. MULLINS,
HAROLD CHAPPLE, } House-Surgeons.

Appointments.

Civil.

BARBER, HUGH, M.D. Lond., M.R.C.S., has been appointed Assistant Physician to the Derbyshire Royal Infirmary.

DAVIDSON, A., M.D. Brux., M.R.C.S. Eng., L.R.C.P. Lond., has been appointed District Medical Officer and Public Vaccinator to Thorpe S. Andrew, Norwich.

Naval.

Surgeon S. S. SHANNON, R.N., is promoted to be Staff Surgeon, R.N.

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

The Biennial Dinner, 1910.

DEAR MR. EDITOR,—I am very much obliged to you for inserting my previous letters in reference to the Biennial Dinner. I now send you the list of names of all those who have signified their intention, up to to-day, of being present. Dinner tickets have been sent to those whose names are included in this list, and I would ask everyone to send me back *immediately* the whole form accompanying the ticket. If this is done, I hope to be able to arrange that each diner will find himself seated amongst his own particular group of friends. It will be impossible for me to carry this into effect for those whose replies do not reach me by Saturday, June 25th.

Needless to say, if there are any Guy's men who have not yet decided to come, but who find at the last that they are able to do so, or if there are any who, when looking over this list, discover the names of some old friends which induces them to accept, I hope they will not think it too late to apply to me for a seat. I can include any names received up to the last post on Saturday, June 25th, and shall be glad if such late applicants will send me a list of the names of those near whom they would like to sit.

The list of acceptances so far is most encouraging, and if only a few more will come in, it is possible that this year may even rival the record attendance of 1908, viz., 331. The Connaught Rooms afford ample accommodation for a very large number of diners, and so there is no chance of overcrowding. There are to be no speeches, nothing more than the toasts of "The King," "The Chairman," and "Our Old Hospital and School," proposed in so many words, and therefore there will be plenty of time for men to talk to those whom they have not perhaps seen for many a year. We have, too, the good wishes of many who have written to me much regretting their inability to attend this year, and trusting we may have an enjoyable evening, and as successful, or if possible more so, than these dinners have proved themselves to be in the past.

I am, yours sincerely,

66, Wimpole Street, W. JOHN FAWCETT,
June 23rd, 1910. *Hon. Sec.*

LIST OF MEN ATTENDING THE DINNER.

Names sent in by June 22nd.

1849—1869 (inclusive).

1849*	Bryant, T.	1863	Nichols, R. T.
1852	Pavy, F. W.		Ray, E. R.
1856	Barnes, J. E.	1864	Savage, G. H.
1858	Rand, J.	1865	Elphinstone, R.
1860	Tanner, J.	1866	Bosworth, J. R.
1862	Minns, P.		

*Date of first qualification.

1867	Chapman, C. W.	1869	Durham, F.
	Sangster, C.		Gillingham, A.
1868	Brookhouse, C. T.		Lacey, T. W.
	Higgens, C.		Taylor, W. B.
	Taylor F.		Townsend, T. S.

1870—1879 (inclusive).

1870	Branfoot, A. M.	1875	Brown, Thos.
	Jalland, W. H.		Elcum, D.
	Matcham, A.		Lancaster, H. F.
	Oram, R. R. W.		Symonds, C. J.
	Tulk-Hart, C. J.	1876	Mansell, E. R.
	Waller, W. A. E.	1877	Beale, E. C.
1871	Clapham, W. C. S.		Davy, H.
	Ewart, J. H.		Lane, W. A.
	Goodhart, J. F.		Uhthoff, J. C.
	Younger, E. G.	1878	Bryden, R. J.
1872	Armstrong, R. S.		Buxton, A. St. Clair
	Brailey, W. A.		Hearnden, W. F.
	Golding-Bird, C. H.	1879	Bates, L.
	Turner, George		Howell, T. A. I.
1873	Nash, W. G.		White, W. Hale
	Pinching, C. J. W.		

1880—1889 (inclusive).

1880	Ashwell, H. G.	1884	Muspratt, C. D.
	Newnham, W. H. C.		Randell, R. M. H.
	Perkins, G. S.	1885	Beard, F.
	Scott, B.		Bisshopp, F. R. B.
1881	Adeney, E. L.		Lipscomb, E. H.
	Austen, H. H.		Lund, H.
	Blatherwick, H.		Perry, E. C.
	Pitt, G. N.		Rouw, R. W.
	Starling, E. A.	1886	Burghard, F. F.
	Stokes, L.		Greenwood, E. C.
	Warner, P.		Morton, C. J.
1882	Berry, J. B.		Sandoe, J. W.
	Cock, F. W.		Taylor, A. S.
	Dakin, W. R.		Wacher, S.
	Dunn, L. A.	1887	Black, G.
	Fraser, J. A.		Brownfield, J.
	Gibson, J. H.		Randall, P. N.
	Price, J. A. P.		Routh, C. F.
	Sells, H. T.		Rowell, G.
	Woodhouse, C.	1888	Cruickhank, J. D.
1883	Pillin, H. L.		Holman, F. K.
	Shaw, L. E.		Roberts, A. C.
	Targett, J. H.		Scott, A.
1884	Baillie, R. A.		Smith, G. B.
	Brogden, R. W.	1889	Fripp, A. D.
	Counsell, H. E.		Lansdown, R. G. P.
	Kinsey-Taylor, A. E.		Norburn, A. E.
	Maggs, W. A.		Pendlebury, J. F.

1890—1899 (inclusive).

1890	Fawcett, J.	1892	Fisher, W.
	Hickman, H. V.		Sichel, G.
	Spurrell, C.		Steele, K.
	Stevens, T. G.		Thomas, J. D.
	Swayne, F. G.		Turner, F. M.
	Vicars, F.		Young, F. C.
1891	Brown, R. King	1893	Cooper, H.
	Craig, M.		Eyre, J.
	Emmett, J. W.		Little, E. G.
	Hopson, M. F.		Luce, R. H.
	Jewell, J. W. F.		Sharp, H. C.
	Samways, D. W.	1894	Allport, A.
	Smith, G. Pender		Henry, P. F.
	Young, J.		Hovenden, G. S.
1892	Biddle, H. G.		Munro, H. A.
	Daldy, A. M.		Robinson, W. E.

1894	Steward, F. J.	1896	Spon, H. J.
1895	Ashwin, R. H.		Spriggs, E. I.
	Beddard, A. P.		Stewart, H. M.
	Edwards, C. D.	1897	Cardin, H. C.
	Fothergill, E. R.		Cloud, F. H. L.
	Hewetson, H.		Clowes, E. F.
	Key, M. A.		Fremantle, F. E.
	Partridge, A. A. H.		Gough, B. B.
	Payne, J. L.		Mayston, R. W.
	Peters, E. A.		Moore, J.
	Rowland, W. J.		Nicholson, C. R.
	Tyson, W.		Thornely, M. H.
1896	Busteed, J. H.		Turner, P.
	Fagge, C. H.		Way, M.
	Fisk, E.	1898	Eason, H. L.
	Handley, W. S.		Fox, H. E. C.
	Hills, W. E.		McGavin, L. H.
	Knowles, C. H.		Rowland, E. W. S.
	Lavers, N.		Swan, R. H. J.
	Milbank-Smith, H. J.	1899	Curtis, P. J.
	Ormond, A. W.		Miller, A. A.
	Poole, T. B.		Nicholls, F. J.
	Rowlands, R. P.		Walters, J. B.

1900—1910 (inclusive).

1900	Atkins, J.	1906	Malleson, H. C.
	Camps, P. W. L.		Miller, W. H.
	Forsyth, D.		Morgan, E.
	French, H.		Palmer, A. S. M.
	Goadby, K.		Rippmann, C. H.
	Perkins, J. S. S.		Rowlands, R. P.
	Secretan, W. B.		Stebbing, G. F.
	Taylor, J. G.		Trethowan, W. H.
	Thomas, T. P.		Vandermin, H. F.
1901	Clarke, G.	1907	Air, S. H. C.
	Cross, F. G.		Aubrey, H. P.
	Hammond, J. A. B.		Carlyle, H. B.
	Pearson, A.		Cook, W. W.
	Smith, D. W.		Densham, A. T.
1902	Bentley, H.		Digby, K. H.
	Cutler, H.		Flower, N.
	Evans, G.		Henderson, H. J.
	Jackson, F. D. S.		Jones, C. E. M.
	Odgers, N. B.		Laidlaw, P. P.
	Pinching, C.		Leipoldt, C. L.
	Shipway, F. E.		Stead, C. C.
	Trail, D. H.		Zorab, A.
1903	Brailey, A. R.	1908	Basker, C. A.
	Cole, P. P.		Brookhouse, H. O.
	Glanville, L. S. H.		Chapple, H.
	Glendining, B.		Townrow, V.
	Goss, J.	1909	Evans, T.
	Iredell, C. E.		Fitzmaurice, A. L.
	Mann, H. C.		Greenwood, A. A.
	Parker, F. H.		Lucey, H. C.
	Wedd, B. H.		Mullins, H. R.
1904	Chisolm, R. A.	1910	Barber, H. W.
	Hertz, A. F.		Bradnam, C. H.
	Hughes, E. C.		Bromley, L.
	Mollison, W. M.		Brown, T. F.
	Ticehurst. G. A.		Browning, R.
1905	Cameron, H. C.		Bull, F. B.
	Crofts, A. D.		Endean, F. C.
	Payne, O. V.		Mills, C. H.
	Smith, E. B.		Powell, R. W.
1906	Bartlett, G. N.		Saner, J. G.
	Goodhart, G. W.		Seabrooke, A. S.
	Layton, T. B.		Webster, V. T. P.

Also Mr. H. Cosmo Bonsor, The Rt. Hon. Viscount Goschen, Sir Cameron Gull, Bart., Colonel F. A. Lucas, Mr. C. R. G. Hoare, The Rev. W. A. Dunn, and Mr. Neville Cox, Editor of the *Guy's Gazette*.

The Egyptian Society in England.

DEAR SIR,—I have been plagued the last two or three days with questions and letters with regard to "the Egyptian Society in England."

Not being a member, I beg to state that I am not in a position to answer any questions with regard to the said society.

Hoping you will kindly give this publication,—I remain, yours truly,

HASSAN SHAHEEN.

Guy's Hospital, S.E.

DEAR SIR,—May I, through the columns of the GAZETTE, draw attention to a telegram lately sent from the Egyptian Society in England through a fellow-countryman and student?

I am afraid it has caused a great deal of misunderstanding and unpleasantness to those who are in no way connected with the above society.

I myself, not being a member, take this opportunity to express my regret. M. Z. HANAFY.

Guy's Hospital, S.E.

[This subject is referred to in "Passim."—ED., G.H.G.]

Papers by Guy's Men.

Sir Henry Morris, Bart., M.A., M.B. Lond., F.R.C.S. Eng., Three Clinical Lectures delivered at the Middlesex Hospital—

Lecture I.—Lymphatic Œdema of the Leg and Foot, with Cyanosis and Drop-Foot (Illustrated).—*Lancet*, 28th May, 1910.

Lecture II.—On a Case of Aneurysmal Varix in the Leg of a Child, aged 7 years (Illustrated).—*Lancet*, 4th June, 1910.

Lecture III.—On the Operative Treatment for Preventing the Destructive Renal Changes in Hydronephrosis and Pyonephrosis (Illustrated). — *The Lancet*, June 11th, 1910.

"Suggestions" in the Treatment of Disease.—*British Medical Journal*, 18th June, 1910.

Berthon F. Pendred, M.R.C.S., L.R.C.P. Lond.: Artificial Respiration in New-born Infants.—*British Medical Journal*, 28th May, 1910.

Cecil Price Jones, M.B. Lond.: A Source of Fallacy in Counting Red Cells.—*British Medical Journal*, 4th June, 1910.

W. Hale White, M.D. Lond., F.R.C.P. Lond.: Gastrotaxis.—*British Medical Journal*, 4th June, 1910.

J. George Taylor, M.D. Cantab., M.R.C.P. Lond., and W. Foulkes Lowe, A.R.S.M., F.I.C.: Faced Rice as a Danger to Health.—*The Lancet*, 18th June, 1910.

W. Hale White, M.D. Lond., F.R.C.P. Lond.: A Clinical Lecture on a Case of Pernicious Anæmia having changes in the Spinal Cord.

Appointments.

Medical School Appointments.

The following appointments have been made by the Treasurer upon the recommendation of the Medical Council:—

JULY—SEPTEMBER, 1910.

Clinical Assistants.—Messrs. W. S. Kidd, W. T. Clarke, T. D. M. Stout, H. Gardiner, G. H. Hunt, E. P. Poulton.

Clinical Assistant in Medical Out-Patients.—Mr. L. C. D. Irvine (Drs. Fawcett and French).

Dressers in the Throat Department.—Messrs. T. Lewis Jones, W. E. Fox, G. E. Warner Lacey, J. A. Edmond, N. S. Carruthers, A. Stanley Roe.

Medical Ward Clerks.—Extensions.—G. W. B. Garrett, W. S. George (Dr. Hale White); D. A. Davies (Dr. Pitt); T. P. Cole, E. C. Peers (Sir Cooper Perry); M. Pern, F. Tooth (Dr. Shaw). L. B. Stringer, E. C. Cline, M. Scott, W. Matthews, T. I. Bennett, R. D. Passey, H. Webb, J. L. D. Lewis, W. C. Whitworth, K. B. Clarke, H. J. Hoby, J. M. Joly, R. S. Kennedy, F. C. Newman, V. F. Soothill, C. Warner, C. Worster-Drought, T. Hampson, O. R. L. Wilson.

Assistant Surgeons' Dressers.—Messrs. T. B. Heaton, H. C. Godding, W. K. Fry (Mr. Steward); F. C. Hunôt, J. P. Jones, L. P. Harris (Mr. Fagge); A. Tilbury, E. L. Jones, G. W. King (Mr. Rowlands); E. White, E. G. Reeve, A. L. Shearwood (Mr. Turner).

Surgical Ward Clerks.—Messrs. G. E. Genge-Andrews, J. L. Percival, E. M. Mahon, C. H. G. Pochin, G. S. Miller, W. Robinson, H. C. Rook, J. F. G. Richards, T. A. Townsend, W. C. D. Maile, A. G. H. Moore, A. B. Danby.

Post-mortem Clerks.—Messrs. G. R. Hind, H. G. B. Blackman, H. F. Renton, H. P. Warner, H. T. Depree, A. H. Gool (July—September); G. A. Blake, F. G. Lloyd, G. Marshall, T. S. Allen, G. W. M. Andrew, O. E. Williams (August 16th—November 15th).

Clerks in the Skin Department.—Messrs. T. P. Cole, A. J. McNair.

Aural Surgeon's Dressers.—Messrs. L. Mandel, G. Dunderdale, J. A. Edmond, N. S. Carruthers.

Obstetric Dressers.—Messrs. P. J. Monaghan, B. Blackwood, N. Mutch, A. J. McNair, F. D. Saner (Mr. Targett); A. L. Gardner, A. H. Todd, C. D. Killpack, H. L. James, H. Davis, J. B. Hance (Mr. G. B. Smith).

Obstetric Clerk.—Mr. H. F. Renton.

Dental Surgeons' Dressers.—Messrs. N. Mutch (August—September); F. G. Lloyd (September—October); A. Seabrooke (October—November).

Clerk in Electrical Department.—Mr. L. Mandel.

Assistant Physician's Clerk.—Mr. L. M. Menage.

PERIODICALS RECEIVED.—The Hospital, The Clinical Journal, The M.S. Journal, The Nursing Times, South African Medical Record, The Stethoscope, The Middlesex Hospital Journal, St. Mary's Hospital Gazette, Magazine of the London (R.F.H.) School of Medicine for Women, My Journal, London Hospital Gazette, St. Thomas' Hospital Gazette.

Dental News.

Report of the Annual General Meeting of the Dental Society, May 26th, 1910.

The meeting was well attended, and after silence (?) had been established the business of the day was proceeded with, after, to everyone's surprise, only twenty minutes' delay.

The minutes having been read and confirmed, the Secretary gave his report, which was unanimously adopted.

Mr. Aubrey then announced that the next business was the election of officers. According to custom scrutators were appointed, Messrs. Bradnam and Powell being chosen.

The voting was then proceeded with, affording pleasure to many. It is the suggestion of quieter members of the Society that something be done to kill time during the interval occasioned by the counting of the votes; at the meeting some members appeared to think the interval specially arranged for them to kill their friends.

The reappearance of the scrutators was the signal for a burst of cheering, and amidst scenes of indescribable enthusiasm the result was declared as follows:—

President: Mr. H. C. Malleson. *Vice-Presidents:* Messrs. H. P. Aubrey, M. F. Hopson, W. M. Mollison, E. B. Dowsett, J. L. Payne, F. J. Pearce. *Secretary:* Mr. H. D. Shore. *Committee:* Mr. C. T. Watson (for May, 1909), Mr. J. S. Cocks (for October, 1909), Mr. C. H. Medlock (for May, 1910), Mr. S. Wilson Charles (for any year). *Dental Correspondent:* Mr. A. W. Thompson.

Mr. F. Bocquet Bull, on behalf of the members, thanked the President, Mr. H. P. Aubrey, for his services during the past year and the meeting terminated.

Congratulations to Mr. Harold Harrison on obtaining the Newland-Pedley Gold Medal for Operative Surgery.

We are now reaching the end of our half-year, and with it our present House-Surgeons, Messrs. Bull, Bradnam, and Powell, go off, taking with them our hearty thanks for the kindly way in which they have performed their arduous duties, and our best wishes for their future success.

Change of Address.

Dr. and Mrs. Clifford Beale, from 73, Addison Road, W., to Allan Down, Rotherfield, Sussex.

R. J. Gibbings, L.D.S. Eng., from Oudtshoorn, Cape Colony, to 82, Dutoitspan Road, Kimberley, Cape Colony.

Dr. T. G. Stevens, from 8, Weymouth Street, Portland Place, W., to 20, Queen Anne Street, Cavendish Square, W. Telephone, Gerrard 3480.

What is meant by Insanity?

A LECTURE BY DR. MAURICE CRAIG.

As is my usual custom before starting these lectures, I must ask you to banish from your minds all preconceived ideas as to what is meant by insanity. Never use the words "madness," "lunatic," or such obsolete terms, as they convey an entirely different meaning to what I hope to be able to show you is the real meaning of mental disorder. Approach the study of mental disorder in the same way as you would approach any other branch of medicine, as there is really no distinction between mental disorder and physical disorder. The distinction which has been made in the past is purely an arbitrary one, and one which no doubt has its basis upon superstition. It is as useless for me to define insanity, as it would be to define what one means by soundness of mind. Sanity itself is a relative term, and is equally indefinable. Every physician knows what he himself means when he speaks of a normal or healthy body, but would he care to state such an opinion in the terms of a definition? A body may have many blemishes and yet be classed as healthy, for experience enables us to distinguish between those defects which are important and those which are immaterial. So it is with the mind. There is no such thing as perfection in mind or body. Experience alone can furnish us with a knowledge by which we can form a judgment of what, for want of a better term, may be called a "normal standard."

Clearly, then, we ought to understand something about the mind itself before we attempt to gauge the various disorders by which it may be disturbed. I do not wish to worry you with problems of psychology, but throughout these lectures I must briefly touch upon various attributes of normal mind, and point out to you how and why they may become disordered. I shall attempt to instil into you the principles of mental disorder, explaining to you the various symptoms that may arise, and at Bethlem these symptoms will be grouped together in the demonstrations illustrating the various types of insanity as known at the present day.

Now in studying mental disorders there are three main factors which have to be considered:—

1. Self, which is the sum total of sensations, perceptions, feelings, and ideas of any given moment.
2. The environment or surrounding in which we live.
3. The adjustment of the one to the other.

To deal with these:—

1. As I shall show you in a subsequent lecture, in the early months of life we have no idea of personality, and even when the child begins to talk it speaks of itself in the third person; but the normal infant is constantly receiving sensations by which it will ultimately know its relationship to the world. Tactual sensation is the one by which we probably learn the most. A child at first stretches out for objects far beyond its reach, but slowly acquires the knowledge of spatial perception. A child learns a language by which it acquires the knowledge of the thoughts of others. In fact, to put it shortly, a child is continually acquiring, by means of special sense and organic sensations, its future knowledge of self. At the same time, these sensations are being associated with feeling-tones of pleasantness and unpleasantness. Sensations are being stored up as memory ideas, to be recalled again as occasion demands. Every time a movement is made we receive a group of sensorial impressions occasioned by and peculiar to that movement. Diminish sensation and you have, to a certain extent, taken away the consciousness of self. Sensation, then, is probably the basis of the knowledge of self, and, as I shall endeavour to show to you, disorders of sensation give rise to disorders of this knowledge of self. In other words, altered sensation means altered personality. The ego, composed as it is of the sum total of subjective sensations, etc., is continually changing; the ego of one moment is not the ego of the next. Compare yourself, for instance, in health or in pain, when rested or when fatigued, and you will appreciate what I mean by the effect of changed sensations on personality.

2. By environment we mean the different grades of society which we meet and the various circumstances by which we are surrounded, and, as you will appreciate, this, like sensation, is an ever-changing quality.

3. Now it is the adjustment of these two factors which is the very essence of conduct; and when one appreciates that each of them, as I tell you, is a varying quantity, you will recognise how difficult this adjustment is, and any failure of it will tend to place the person out of touch with the community in which he lives.

In insanity we have to deal with this failure of adjustment of self to environment. The patient may neglect the most necessary and

rudimentary requirements of life: food may neither be sought nor eaten even when placed within reach; the ordinary laws of self-conservation may be neglected; rules of personal cleanliness may be unobserved; ability to earn a living may be absent; acts of violence against self and others may be committed; we may be unable to distinguish between what belongs to us and to others; in these and in many other ways the disorder of conduct may show itself.

Society rules that the liberty of the subject is only possible so long as that liberty is not used to interfere with the liberty of others.

Now, for a moment, let us just consider how altered sensation may lead to altered personality, and altered personality in turn may seriously affect our conduct. To begin with, the lesser changes. Let us suppose that the head, limbs, and chest of a patient are anæsthetic. This will give rise to a comparative hyperæsthesia of the abdominal area, and the result will be very similar to what it would be were the abdominal area hyperæsthetic as compared with a normal state of the other parts of the body. This hyperæsthesia permits him to sense sensations which are usually performed unconsciously, and may give rise to disagreeable sensations in the stomach and intestinal tract. In other words, this individual's personality will be largely coloured by the sensations he is deriving from these special areas of the body. The next stage is for this individual to account for the abnormal sensations that he is receiving, and in so doing an erroneous judgment may be formed, and this we speak of as a delusion. And let me tell you at once that a delusion is a false belief, but the question as to whether the person is of unsound mind must be decided apart from the delusions; as clearly a sane person may have a false belief. To the physician the importance, then, is not the delusion, but why the delusion is there. Delusions may bias conduct, and, what is equally important, they form a basis by which a person will collect evidence to favour their ideas and ignore the weight of evidence against them. So again with special sensory disturbances, the patient may hear sounds which those about do not hear, or see objects unseen by others, and although such hallucinations are certainly the product of some abnormal working of the brain, they are frequently found in persons who are perfectly sane in that they are capable of doing their daily work and in every way conforming to the social laws. Therefore, either delusions or hallucinations standing alone and unsupported by other evidence are not conclusive of insanity. But if they co-exist—that is, that the man not only has a false belief, but that this false belief is supported by auditory or visual hallucinations—clearly this is stronger evidence of unsoundness of mind. Further, if in addition there are serious disorders of conduct, then the case is probably one of certifiable insanity. Medical experts, when acting as witnesses in our courts of justice, frequently have their statements in this way dissected by a skilful counsel. They are asked in threatening tones whether they wish to tell the jury that hallucinations are indicative of insanity, that delusions only exist in the minds of the insane, and, maybe, that emotional disturbance, such as depression of spirits, connotes insanity? To each question the witness must answer "No," but let him seize his opportunity to add that when associated together there is strong presumptive evidence of serious mental disorder. Mental is in every way comparable to physical disorder. It is only by the grouping of symptoms that we are able to diagnose various diseases; so it is only by a collection of data that we are able to deduce insanity.

As I shall endeavour to show you, emotions play an important part in the social life of the individual. I have already spoken of "feeling tones," by which one means the pleasantness or unpleasantness associated with simple sensations. But emotions are more complex; the pleasantness and unpleasantness are associated with organic sensations, and changes take place in the secretions; for example, the surface of the body may be bathed in perspiration, the mouth may be dry, or the eyes wet with tears. In health there should be perfect harmony between the emotions and other mental processes, but changes may take place in which the emotions become disordered, and one feeling tone may pass into the ascendant, with the result that the mental life of the individual for the time being is under the influence of this colouring, be it one of gloom or of uncontrolled buoyancy. But here again we come back upon sensation, because emotion is associated with sensations, or former sensations, and is merely the affective side of these sensations. Depression of spirits is normal under certain conditions, but the misery may pass beyond all bounds, and no longer merely colour the original ideas with which it was associated, but colour every action and thought of that individual's life. It is only human nature to endeavour to explain all our sensations and feelings, and it is in explaining disordered sensations and feelings that the maniacal or

melancholic patient forms erroneous conclusions; in other words, the former develops what we choose to call "delusions" of exaltation, and the latter "delusions" that he is lost or ruined.

Attention, again, is an attribute of mind, and in health we ought to be what is called poly-ideational, that is, we should be capable of concentration on any subject which at the moment demands our attention. On the other hand, we may become inattentive. Concentration upon a subject may become impossible, and we may pass into a condition closely resembling a dream state, a condition in which extreme inattention is one of the chief characteristics. Or the disorder of attention may be that of hyper-attention, a state in which one idea is constantly asserting itself into consciousness. And perhaps this is one of the best illustrations I can give you of what one means by unsoundness of mind, and how near it is to health, and yet how close it may be to a state of certifiable insanity. An obsession is a morbid impression or idea imperiously demanding notice; in other words, one thought is constantly forcing itself upon us. Turning off the gas at night is a common type of obsession. As soon as a man has put out the light the thought occurs to him that he may not have properly turned off the tap, and he returns to inspect it. So far there is nothing abnormal, as he does nothing more than a conscientious person might do. But suppose that he no sooner reaches his bedroom than he begins to wonder whether in removing his hand after turning off the light he just touched the tap again, and may have caused an escape. For a time he may resist the impulse to go down and inspect the gas-bracket, but gradually the idea becomes more and more reinforced, as he thinks of the consequences that may arise, until he ultimately gives way. You may consider that, so far, all the man has done is to doubt the fine adjustment of his fingers in the performance of a movement. He is once more back in his room, when the old idea again haunts him. He recognises the folly of it, and refuses to obey its dictates. He tries to think of other things, but his attention always reverts to the one thought, and in desperation he again returns to inspect the gas-pipe. With each recurrence the mental state becomes one of greater agitation. Not only is he disturbed at the repetition of the thought, but his powerlessness to disregard it. And you can see that if the obsession recurs frequently enough, if it occasions disturbance of his sleep, if, in other words, he is spending the night in a state of mental agitation, his conduct has by now become so disordered that he may have passed within the realm of certifiable insanity. Also other symptoms may have developed; active depression, with all its concomitant symptoms, especially that most trying one of all, the feeling that life is not worth living, which may at any time end in an attempt at self-destruction.

Memory, again, is an important attribute of the mind. The healthy brain should be able to store fresh impressions, and new facts should become associated with former ideas. Loss of memory may seriously affect conduct, and an amnesic person may seriously contravene moral and social codes; or it may lead to such disorientation that he is unable to know his whereabouts.

I think I have now given you sufficient illustration to prove to you how altered sensation may lead to altered feelings, and how each or both may so affect our personality that our outlook upon life may become entirely changed. If you wish to understand mental disorder and how a person feels, you may study it yourself in the different phases of your mental life. Analyse your feelings on your most gloomy days and try to imagine yourself ten times more miserable, and then you will have some idea of what depression really is. When you are worried you are unable to settle to anything; you pick up a book and try to read, and soon close it, as you cannot fix your attention upon the subject. Imagine yourself always in this state and you will have a faint idea of real mental disorder. As a child you may have experienced the feeling that someone was following you as you hurried along some dark lane or passage; imagine yourself always in this state and you will have a slight conception of what it is to be haunted by the thought that you are being continually followed. Go by underground railway to some station that you have never been to before, and as you stand outside the station you look round and the sensations which you receive give you no feeling of familiarity, and you become totally disorientated, not knowing your whereabouts or which way to turn to reach the place you seek. Such temporary disorientation will give you some slight insight into the state of a man who has more permanently lost his memory; in other words, his knowledge of people and things.

If you endeavour to analyse mental disorder in this way, the subject will at least become intelligible, and will no longer appear to you to be a mere concatenation of strange symptoms. The error that most persons make is, that they fail to realise that insanity consists largely of

exaggerations of those mental aberrations to which the majority of individuals are liable.

To sum up, mental unsoundness may be either due to failure of evolution or a result of dissolution. The former is usually classed under the headings Idiocy, Imbecility or Congenital Mental Enfeeblement. Now, by failure of evolution all we mean is, that the attributes of mind which should have developed during the early years of a child's life have not done so, and that the child reaches maturity lacking in control, devoid of moral sense, with no power of attention, or is in some other way defective in its mental equipment. On the other hand, just as we have acquired various attributes of mind (largely, as I have shown you, by means of our special sense sensations), so we may again lose them owing to disease. When we do lose them, we do so in the inverse order to that in which we attained them, the latest acquirements being the first affected. Even with fatigue, we have lessened power of attention, diminished power of association, which, in turn, affects our memory. We find muscular movements become uncertain, as shown by the comparison of the handwriting in healthy or fatigued states. Our powers of control are lessened, as exhibited by outbursts of irritability, and our judgment becomes inaccurate and unreliable. Loss of control is shown again by restlessness or fidgetty movements, which closely resemble those observed in children. The weary man of business paces up and down his office trying to concentrate his thoughts, and the more exhausted he is the more energetic he becomes.

Many of the early changes are similar to those of fatigue conditions, and they become progressively more marked, especially if, as is usual, the importance of them is not recognised, or they remain untreated. As the condition advances, the various systems of the body become affected, and insomnia may hasten the collapse. Whilst all this is taking place, the conduct begins to change, and becomes more and more uncertain. It is then that the question arises whether the day has not come when the patient should be placed under care. When we come to discuss treatment, I shall impress upon you the importance of recognising these early changes, for the longer one works at disorders of mind, the more convinced one becomes that the more serious disturbances are due to the early symptoms having been overlooked or neglected. Disordered sensation or strong emotion may usurp the whole attention, sensory illusion may deceive the man, or profound depression may paralyse both thought and movement. But, let it be remembered, insanity is not revealed by one symptom; the change can be seen in everything, physical or mental. The dissolution may be uneven, and the degeneration in one part may far exceed that of another; nevertheless, the whole is affected. In determining insanity the evidence to establish it cannot be decided from one symptom. The symptom present may be regarded much in the same way as pieces of circumstantial evidence are during a trial. Each individual piece may denote nothing, but the chain formed by welding the separate pieces together may be so strong as to compel one conclusion. So with the symptoms of insanity; each of them if present alone might be consistent with sanity, but taken together they may form so strong a body of evidence as to force the inference of insanity.

Pass List.

University of Cambridge, June, 1910.

The following gentlemen have been appointed examiners for the ensuing academical year:—

In Medicine.—G. Newton Pitt, M.D., and Frederick Taylor, M.D.

In Surgery.—F. F. Burghard, M.S., F.R.C.S., and L. A. Dunn, M.S., F.R.C.S.

EXERCISES FOR DEGREE OF DOCTOR IN MEDICINE.

W. Ledlie, M.A., Christ's.
H. Ackroyd, M.A., M.B., B.C., Caius.
F. Shufflebotham, M.A., M.B., B.C., Trinity.

DEGREES CONFERRED.

M.D.—W. Ledlie, Christ's, and F. Shufflebotham, Trinity.

M.B., B.C.—B. Wallis, Trinity, J. Walker, Clare, and A. B. Carter, Jesus.

B.C.—W. Ledlie, Christ's.

PASS.—DIPLOMA OF D.P.H.

A. H. G. Burton, M.B., B.S. Lond.

BOOKS AND JOURNALS RECENTLY RECEIVED IN THE LIBRARY.—Latest editions of Sims Woodhead's Practical Pathology, Fuch's Ophthalmology, and Eden's Midwifery; Oppenheimer's Handbuch der Biochemie, 5 vols.; Box's Post-mortem Manual; Treves and Hutchison's Operative Surgery, 2 vols.; Dieulafoy's Medicine, 2 vols.; Goodhart and Still's Diseases of Children; Churchward's Signs and Symbols of Primordial Man; The Dental Directory; Zeitschrift für Röntgenkunde und Radiumforschung (monthly); Zeitschrift für medizinische Electrologie (quarterly).

The Permanence of Tooth Fillings.

DENTAL

CLINICAL LECTURE BY MR. J. A. PARFITT.

GENTLEMEN, — The permanence of a filling depends on the fulfilment of certain conditions, which may be classified as relating to :—

The environment of the tooth,
Its structure,
The joint between the tooth and the filling,
The properties of the filling material.

With regard to the first question, it must be confessed that the environmental conditions that determine the incidence of dental caries are still rather a mystery. The wonder is that any teeth escape at all, but whatever is the cause of the immunity that most teeth enjoy, that cause must of necessity act through or in connection with the saliva. It is a well-known fact that thick, ropy saliva, is frequently associated with widespread and rapidly advancing caries; moreover, oral hygiene certainly has some influence on the course of tooth decay, as the following case shows: A young lady who was undergoing treatment in a Sanatorium presented herself for dental attention, and was found to have a number of cavities which were evidently increasing rapidly in size; many of these were on the labial surfaces of the teeth, some of which, although not actually hollowed out, showed crescentic patches of decalcification along the gum margin. It transpired that she was taking milk in considerable quantity, and at such times that it was hardly possible for her mouth to be free from fermentable material for any long time together. The cavities were filled, and she was advised to clean her teeth every time after taking the milk and after each meal. The tendency to decay immediately ceased, and ten years afterwards the white patches of enamel decalcification had made no further advance. Brushing with plain salt water after each meal has been stated on high authority to be an infallible preventive of caries along the cervical festoons.

What may be called an artificial liability to decay may be produced in one or several teeth by bands or clasps, especially ill-fitting ones.

The environmental conditions of a filling vary with its position on the tooth, as different parts of the same tooth have different degrees of liability to caries. Apart from actual defects, the most vulnerable parts of a tooth are those looking towards and overshadowed, as it were, by its neighbours. The reason for this liability is the lack of natural cleansing that other parts of the tooth get from the tongue, lips, and particles of food. The efficiency of the natural cleansing depends largely on the kind of food that is eaten, as Dr. Sim Wallace has demonstrated. He points out that such an article as an uncooked apple, being hard, excites vigorous mastication, its particles exercise a detergent action on the teeth as they are forcibly driven over their surfaces, and the cleansing is rendered still more efficient by the copious flow of saliva excited by the acid flavour, the secretion continuing for some time after the meal is finished.

Inasmuch as mastication is so important a factor in the self-cleansing of the teeth, irregularity of the arch, with its consequent malocclusion, is a predisposing cause of caries. The occurrence of a cavity starts a vicious circle by favouring food retention, and very likely causes decay in the adjoining tooth that otherwise might have escaped.

It is a well-established fact that only fully-exposed surfaces of a tooth are attacked by caries; even an overlapping margin of gum is sufficient to prevent primary caries in the part of the tooth covered by it, although it is quite unable to protect it from decay that spreads from other regions.

These facts have an important bearing on the permanence of a filling. Any part of its margin that is under the gum is generally safe from further decay, provided it is satisfactory in other respects. The edge of the filling should also, if possible, be outside the interstitial danger zone. A good rule for interstitial fillings in molars and bicuspids is to have the labial and lingual margins sufficiently far away from the contact point to be visible from the front in the case of mesial cavities, in a corresponding fashion in the mirror in distal ones. The further the teeth are from one another the more easily does the self-cleansing take place, and the smaller is the danger area; hence a wide inter-dental space, gained if necessary by separation, enables us to place the filling margins out of danger from recurrent decay without sacrificing much tooth substance.

The proper shaping of the inter-dental space is a matter that deserves much more attention than is very often bestowed upon it. Its importance will only be appreciated if the mechanics of mastication are understood together with the adaptation of the tooth forms thereto. It must be remembered that the teeth of an animal, like the teeth of a saw, lose much of their value unless they are of just the proper size and shape,

and placed in exactly the correct relation to one another. In a perfect arch it will be found that the occlusal surfaces of the cheek teeth of one side of the upper or lower jaw form a continuous trench bounded laterally by the lines of labial and lingual cusps; the mesial and distal ridges of the crowns fit together so well that the floor of the trench is practically unbroken, the chinks between tooth and tooth being less noticeable than the fissures of an individual tooth, as is evident from the fact that small seeds collect in the crown fissures, but not in the interdental spaces unless they are abnormal in shape. These points on the mesial and distal ridges are the only ones in which the teeth touch one another, the surfaces trending away from one another in both vertical and horizontal sections. In health most of the space beneath the contact point, which constitutes the "danger zone," is filled up by the tongue of gum called the "interdental papilla," which is a most important protection to the parts of the teeth which bound the space.

Pits and fissures which favour lodgment of food are notoriously liable to be attacked by caries. Lack of self-cleansing also explains the vulnerability of the cervical third of the labial—or more rarely the lingual—surface of a molar or bicuspid.

In view of these facts, prudence would suggest the rule that a known vulnerable area should be entirely included in the preparation of any cavity that encroaches on it at all.

The permanence of a filling depends in no small degree upon the quality of the tooth substance remaining, especially the enamel. Good enamel has very great powers of resistance to the attack of caries, as may be seen from the fact that it is often found persisting as a thin shell long after the decay has destroyed the whole substance of the dentine beneath it. If the enamel is defective in any way its resistance will be much lessened. Defects may be due to faulty development, decay, or traumatism.

A developmental defect may be of any degree up to complete absence of the enamel over some portion of a tooth; if it is nothing more than a polished white patch it probably has no detrimental effect at all. Defects due to caries are much more serious. In the later stages the mischief is easy to detect, and its treatment clearly indicated. At its commencement, however, enamel decay only shows itself as a white patch *which is not polished*. In some situations this incipient enamel decay is not easily recognized, especially as it sometimes starts in several separate foci at the same time. The occurrence of one or several of these "unglazed" white patches is a sure indication of an actual danger area which should be completely cut out and filled, however far the incipient decay extends over the surface of the tooth. Traumatic defects sometimes occur in the process of filling, especially in gold filling, and when a mallet has been used. Porcelain inlays owe some of their proved lasting power to the great care taken in the preparation of their enamel margins and to the absence of any danger of spoiling them in the insertion of the filling. Traumatic defects, both during filling and afterwards, are much less likely to occur if due attention has been paid to the enamel cleavage planes while preparing the cavity. Unlike dentine, enamel has definite directions of cleavage, and if the margin has not been prepared so that *all the planes of cleavage run down to the dentine*, the sharp edge of the margin will very likely chip off under quite a small stress. Hand chisels are more likely to remove unsupported corners of enamel than are stones or burrs revolving in the engine, because they do not so much cut the enamel as split it along its natural planes of cleavage.

The quality of the dentine which forms the walls and floor of the cavity is a matter of the utmost importance. Although dentine has no cleaving planes like enamel, it is very necessary that its strength should be in no wise impaired if it is to form the bounding walls of a filling, and also that there should be no prospect of such weakening in the future. The only way to be reasonably sure of this is to remove the whole of the decayed part in preparing the cavity for filling. Microscopical examination teaches us that dentine is infected by bacteria for some distance beyond the zone of softening, but experience shows that this "advance guard" is impotent for mischief if the whole of the softened dentine is removed and a satisfactory filling introduced into the cavity. Careful search is sometimes required for finding the outlying portions of the decay. Caries, being dependent on the action of bacteria, naturally follows the lines of least resistance to their advance; of these there are two, one along the line of the dentinal tubules and the other at right angles to them. The first need not detain us, as advance in that line merely leads to the deepening of the cavity and can very readily be recognised; the spread of decay in the other direction, along the incremental lines of the dentine, is far less easily detected and its non-removal followed by more serious results. The spread of softening along the dentino-enamel

junction is of especial importance, as the cusp of a molar or the incisive edge of a front tooth may be rapidly undermined from a comparatively small interstitial or crown cavity; this decalcified layer may be quite thin at its margin and so evade any but the most careful search; if it is not removed the filling will almost certainly fail in a short time. Some of the later incremental lines are marked by the presence of interglobular spaces; in section these appear as a line, but in reality they form a zone in the substance of the dentine, which is such a favourable medium for the spread of decay that sometimes the whole masticating surface of a molar may be lost with such rapidity that the caries is cured spontaneously by exposure of the decayed surface to the cleansing action of mastication.

The nature of the joint between the filling material and the tooth substance has an important bearing on the success of the restoration. There should be no projecting edge of either enamel or filling, and a probe should pass from one to the other without any difference of level being felt, as any roughness at the edge will cause lodgment of food, and so favour recurrence of decay. The degree of apposition is also important; the ideal condition would be actual adhesions such as exist in a cement filling, but such a joint as can quite well be made with gold is sufficiently good to protect the tooth from decay completely and indefinitely; unfortunately the same cannot be said for amalgam, because we can never be sure that changes will not occur in its substance resulting in a drawing away of the filling from the enamel margin; as a matter of fact, the apposition between gold and tooth substance is altogether unique in that it is packed against the cavity wall under pressure; in the case of dentine this pressure causes a slight yielding of the elastic wall, which, by its resiliency, actually holds the gold in what may be called a positive grip as opposed to the mere passive apposition, which is all that can be obtained in the case of a plastic filling. The joint between tooth substance and a cemented inlay deserves especial mention; it is a well-known fact that cement suffers disintegration when exposed to the action of the saliva, and there is no reason why it should be exempt at the margin of an inlay, yet it is a fact that well-fitting inlays make remarkably permanent restorations. The reason for this is that the rapidity of solution depends not only on the nature of the substances concerned, but on the rate at which the saturated solution can be removed, so that the solid may be exposed to a fresh portion of the solvent. In the case of a well-fitting inlay the cement is in a very thin layer, which only presents its edge to the solvent action of the saliva, hence the washing away of the saturated solution is accomplished comparatively slowly, and as the fine chink gets filled up with insoluble particles and greasy material, the fluid in contact with the cement stagnates and solution ceases altogether.

The nature of the filling has, of course, a most important bearing on its lasting properties. Besides being of such a shape that it has firm anchorage without weakening of the tooth, it must be free from any harmful action on the tooth tissues, and from any change of form or bulk, and it must be capable of taking and keeping a good polish. Harmful action on the tooth may be due to irritation of the nerve fibrils by physical means, such as conductivity of heat or electricity or by chemical poisoning, first of the fibrils, later on of the pulp itself. Freedom from secular change is unfortunately difficult of attainment: amalgam is liable to undergo internal molecular changes which may result in gradual alterations of form, bulk and strength; these changes are at a minimum in the hard, rich in silver, alloys which have been made since the classical researches of Dr. Black. Most of the cements suffer loss of substance both by wear and the solvent action of the saliva. Gold and porcelain are free from solution and from internal change, but even they may in some cases be damaged by an abnormally heavy bite, cast gold least of all. The polish of a filling is a most important matter, and one very liable to be neglected; the natural surface of the enamel is as smooth as glass, and the filling must be like it if the adjoining space is to be "self-cleansing." Interstitial fillings are the most difficult to polish, and also the ones in which a smooth surface is most essential, as any roughness tends to start decay in one or both of the adjoining teeth.

It will be seen that the conditions here outlined are not all equally under the control of the operator; moreover, patients vary so much that in some mouths almost any sort of filling will last, while in others the best made ones may fail; nevertheless careful attention to the principles indicated in the preceding remarks will certainly ensure a high average of permanence in fillings.

Cases for Commentary.

Set in the Examinations for the Treasurer's Gold Medals.

Medicine.

William L., æt. 45, was admitted for "spitting blood."

Personal history.—Patient is a pensioner, who served for some years as a soldier in India. There is a doubtful history of syphilis.

Previous history.—He has always been a healthy man except for several slight attacks of ague whilst in India.

Present illness.—He has not felt well for the last ten days, but has not been ill enough to leave off work. The principal symptoms from which he has suffered have been headache, and a disinclination for food. On the morning of the day of admission he went to work as usual, and, after he had had his dinner and was smoking his pipe, he noticed that he spat up "a lot of thick red blood." He at once got leave to come to the hospital, and on his way up vomited freely. When seen in the surgery, he was just recovering from a "shivering fit," followed by a cold and clammy perspiration. His temperature was 100·6° in the surgery, and a little above normal in the ward.

On admission.—The patient is a well-developed man; his face is flushed, and he is troubled by a frequent cough. Pulse, 100; respirations, 28; temperature, 99.

Physical examination.—Impulse of the heart in the 5th intercostal space, well within the nipple line. No thrill; normal cardiac dulness; heart sounds, normal. The radial artery was neither thickened nor tortuous. The patient breathes with considerable difficulty in short, gasping respirations. Both sides of the chest move equally. On percussion there was a good note on both sides, and a few râles were heard in the left axilla. He was expectorating a little streaky blood-stained mucus. The urine had a specific gravity 1030, with an acid reaction. It was amber coloured and contained a little albumen; no sugar or blood. Abdominal viscera normal; nervous system normal. Pupils equal; eyes re-act to light and accommodation.

On the following morning the temperature was 103·8°, and it was noted that during the night he had spat up a large quantity of frothy mucus, mingled with blood, the expectoration being free from smell. On percussion, a dull patch was found at the upper part of the right chest in front; the breath sounds over it were faint. There was no bronchial breathing, bronchophony, or pectoriloquy. The radial pulses were thought to be unequal, and the räles in the left axilla were persistent.

On the afternoon of the same day, the physician saw the patient and examined him, and, a few minutes after he had passed on to another bed, he was called back to find him with limbs convulsed and gasping for breath. The cardiac impulse was strong, but the pulse almost imperceptible at the wrist. The pupils were dilated; the face very pale. He was given an inhalation of Amyl Nitrite, and so far recovered as to sit up in bed, and to speak to those around him. Shortly afterwards, however, he had another convulsive attack, and presently expired, the heart continuing to beat for a short time after breathing had ceased.

Comment upon the above case, and describe what you would expect to find at the autopsy.

Surgery.

CASE I.

E. W., a woman, æt. 20, was admitted for abdominal pain. She had not previously suffered from any illnesses, excepting measles and whooping-cough as a child.

On Tuesday, May 4th, patient was suddenly seized with sharp pains across the abdomen and was very sick. During the following week the pain constantly recurred, but seemed to be confined more particularly to the right iliac fossa, and the patient was frequently sick.

On May 11th patient was admitted to hospital; her abdomen was rigid. She was extremely tender in the right iliac fossa, where a lump could be felt. The urine was normal, T. 100·4, P. 112, R. 28. There was a primary syphilitic sore on the right breast. At first patient was only permitted to take a little water, but temperature and pulse in a few hours came down to normal, and by May 17th patient felt much better and began to take solid food.

On May 24th and 26th patient had rigors, the temperature rising to 104°, but in the interval she seemed much better, cheerful, and did not complain of pain or tenderness in the abdomen.

On May 28th the temperature was still high, the appearance was anæmic, pain in the right hypochondrium was complained of, and something could be felt below the right costal margin. Rectal examination showed nothing abnormal.

A laparotomy was then performed. Pyrexia continued. Discharge from the wound gave a pure culture of Bacillus Coli Communis, and Bacillus Coli Vaccine was later administered.

On June 8th patient appeared distinctly jaundiced, the temperature was 104·4°, the urine was brown in colour and contained traces of bile. Next day the jaundice was less marked, but patient was distinctly worse. She gradually became weaker and died on June 12th.

Discuss the diagnosis and treatment. What was found at the operation, and what was seen at the autopsy?

CASE II.

P. G., male patient, aged 27, foreman carman.

Tuesday, August 4th.—He sustained two severe blows from the shaft of his cart on the scapular region. In the evening there was pain at the site of injury.

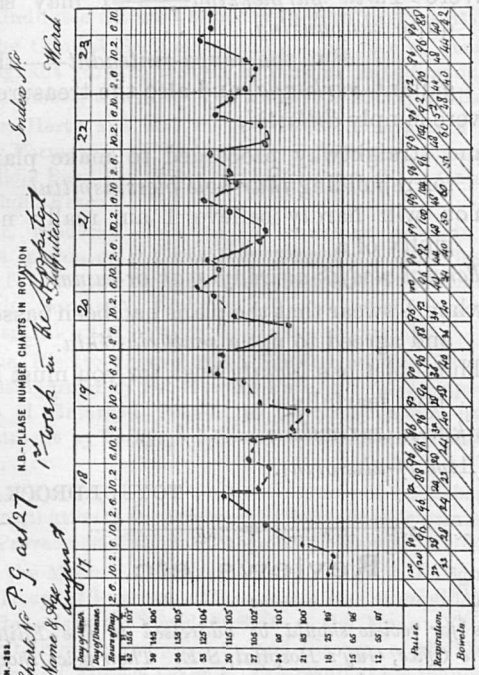
August 5th.—The pain was much worse, preventing him from work. A lump had appeared on the right infra-spinous region of the scapula. There was no cut or abrasion of the skin.

August 6th–10th.—Treated by F. Iodi locally, but became rather bigger.

August 10th.—The mass incised under anæsthesia, no pus found, only indurated tissue that bled freely.

August 15th.—Swelling had increased; it was thought to fluctuate.

Monday, August 17th.—On admission to the hospital, he lay in an apathetic manner, was very pale and sleepy, but could answer questions with an effort. The breath was very offensive; the mouth foul. There was a mass over the right scapula, some four inches in diameter, red, tender, and indurated; it was, however, smaller than it had been two days before. Skiagraph examination revealed no abnormality. A Bier's cup was applied daily; a vaccine of streptococci obtained in pure growth from his gums was made and administered.



August 20th.—The left elbow became painful and swollen; it was aspirated under anæsthesia.

Report: "Cultivations from the fluid of this elbow-joint remained sterile after two days' incubation."

August 25th.—Fluid re-collected in the elbow. Pain, but no swelling, in many of his other joints. Some deficient air entry at the right base.

August 26th–September 8th.—The temperature remained up. The pulse ran at 100 to 124, and at the end of this time was becoming weaker.

September 9th.—Last night his temperature fell to 96·2° F., but went up again this morning.

September 12th.—He died.

Discuss the diagnosis of the case. Could any further examination have been made to clear it up? Might any further treatment have been adopted? What were the conditions found post-mortem?

Solutions to Cases for Commentary.

MEDICINE.

At the autopsy 52 ounces of clotted blood were found in the right pleural cavity.

The condition of the right lung is thus described in the Museum Catalogue (No. 248):—

A right lung, a portion of the upper lobe of which has been removed to exhibit, towards its base, a ragged cavity about an inch in diameter. The lung tissue around the cavity is consolidated by pneumonia. Within the cavity the blue rod indicates a large branch of the pulmonary artery, the ulceration of which led to fatal hæmorrhage. A communication between the excavation in the lung and the pleural cavity is marked by a red rod. There is recent lymph upon the pleura.—See Insp., 1891, No. 119.

SURGERY.—CASE I.

This was a case of appendicitis, followed by suppurative pylephlebitis. On admission, appendicitis was diagnosed, but, as the symptoms steadily subsided, no operation was then performed. After the onset of high temperature and rigors, suppurative pylephlebitis and subphrenic abscess were considered. The abdomen was first opened through the upper part of the right rectus sheath. No pus was found in this situation, so a second incision was made in the right iliac fossa and an ulcerated appendix removed. This lower wound was drained, and continued discharging till the patient's death.

At the autopsy, the tissue round the stump of the appendix was œdematous. The portal vein contained adherent thrombus, and the liver was partly adherent to the diaphragm, and showed, on section, small abscesses filled with bile-stained pus. The lower lobe of the left lung was covered with adherent lymph, and the spleen showed recent capsulitis. The other viscera were normal.

CASE II.

This case was one of glanders pyæmia. *B. Mallei* was found in the blood during life by Straus' test, and *post mortem* in the larynx, liver and spleen.

Scientific Research.

In connection with the annual grant voted by Parliament in aid of scientific investigation concerning the causes and processes of diseases, Mr. Burns, the President of the Local Government Board, has authorized the following special research:—

A continuation of an investigation on the injurious gases evolved during artificial illumination, by Dr. J. Wade. D.Sc.

In Lighter Vein.

THE TABLETS OF MR. NŪTIN, THE WHAWD-KLARK.

(With apologies to E. T. REID, of *Punch*.)

[1ST FRAGMENT.]

1. In the days of *surkoupa* the *soupa-rintendnt*,
2. *hûz* surname was *périh*
3. [no relation to *pîreh* the agent for *bhov-reel* and
4. *pîta-smilkk-choklét* in climes that are cooler than
5. *whéting* about for a *pîr-ilekt-serdjen* in *dhraftik-olonnédz* . . . .].
6. . . . did the *Hosspittul* flourish.
7. There never were *Serdjens* so *uttallih-skillih*, so *palpublih-purphekt*.
8. No *Fiz-zishons* more subtle than those of the boro'—the land of the
9. *Hoppaz*.
10. They proved such an *ehtrakshon* to *Medikkul-yankihs* that droves of the latter crossed over the
11. *Phishpond* and camped round the *Spittul*.
12. They swarmed into the *whawdz* in such *hawdhz* and such numbers
13. That *Meddikhul-whawd-klarkz* were as hard to discover as *Tî-Bhî* in *sputum*. . . . .
14. They insisted on asking, in tones that were *néhzul*, for
15. *dokhtaléhnz-thîrta* . . . . .
16. the *Pléhtaruv-phîmuz*, the *Kol-ektaruv-kolunz*,
17. the *Palléh-trip-aira*,
18. *hûz* new *opparéhshons* are never the *phashun* till twenty years
19. *léhta* . . . . . did welcome the *lottuvum*.
20. When completely enclosed in *asterih-laizd-overawl*, like young boys in a *sakrhace*,
21. they were gently permitted to enter the *thîrta* . . . .
22. They would *djossel* the *barren* about to perform on *aning-winalhurnear*.
23. After tea in the *kollidge* they would strenuously strive to secure the best places for watching the *oppz*
24. of the *rhezidnt-serdjen*, the remover of fingers, the *Ekstrakturuv-nidols*, ...
25. the *Ovadun-undadunner*.

* * * *

26. Now the name of the *strît* that the *Hosspittul* bordered,
27. *a prerfettik-servéhur* had *krissend* the "Mazepond."
28. For the recentest building resembled a puzzle —resembled a warren in *plarz-turan-mawta*.
29. *Itz-rhammi-phaik-éshons*, *kernekshons*, *ub-strukshons*, *itz-multid-awd-chéhmbas*, *itz numarus-starewéhs*,
30. Not to mention—
its-off-thalmol-ojikul-darkrumz
31. Were *Tû-tû purplekzing*———I may say quite *kunphuzing*.
32. . . . . But the *soupa-rintendnt*——the gallant *surkoupa*, and also the treasurer,
33. were simply *dillaitid*,
34. and straightway proceeded to make plans for rebuilding *thur-hole-blessidspittul*.
35. You will hardly believe I am really not guilty of a
36. *Termin-olodjik-al-wadyumak-or-lumm*
37. when I swear that the plans had been passed and agreed to not a *senturih-léhta*.
38. The tablet has *luckily* bust, for you must be most fearfully
39. *sikur-thizdrivul*. . . . .
40. (*Aimorf-ulis-orih*).

TOYFULDROCK.

Reviews, etc.

Books for review should be addressed to The Editor, Gazette Office, Guy's Hospital, S.E. Their price should in every case be stated.

Proceedings of the Royal Society of Medicine, May, 1910. (Longmans, Green & Co.) Price 7s. 6d. net.

The current number of the "Proceedings" opens with the continuation of a discussion on Arthritis Deformans, following on Dr. Llewelyn Jones' paper on that subject. Dr. A. E. Garrod's contribution to the discussion is contained in this part, and is of particular value. "It can hardly be questioned," he says, "that the chapter of chronic diseases which affect the joints is an opprobrium of medicine and the despair of medical students, who

find it hard to obtain from what they read in their text-books any clear light upon what they see with their eyes," and he then proceeds to give a very clear account of the pathology and clinical features of rheumatoid- and osteo-arthritis, considered as distinct diseases. Dr. P. W. Latham, in the same section, explains his theory that "the changes in the joints and the muscular wasting, which are characteristic of rheumatoid arthritis, are due to irritative and destructive lesions located in the spinal cord, and especially in the cervical and lumbar enlargements," and describes his treatment by counter-irritation which is based on that view.

Dr. H. E. Leigh Canney, in a paper on "The Climate of Egypt and North Africa," speaks of the dangers of "chill" in that climate, and remarks, "Unfortunate is the patient whose doctor's mind is not large enough to admit any other view of disease but a microbic one."

The Section for the Study of Disease in Children contains a paper by Dr. Frederick Langmead on "*Eighty Consecutive Cases of Wasting Infants Fed on Undiluted Citrated Milk*" with gratifying results.

The Clinical Section contains a number of cases of malignant growths treated by radium, including one of rodent ulcer, treated by Dr. Iredell for Mr. Symonds.

Dr. Hertz and Mr. F. S. Adams contribute a case of "Formation of Cholesterol Gall-stones containing Typhoid Bacilli within Sixty-eight Days of the Onset of Typhoid Fever."

Mr. Frederick Eve has an important paper in the same section on "Three Rare Tumours of the Base of the Tongue (two of them Endothelioma), with remarks on the Surgery of Malignant Disease of the Tongue," illustrated with photographs of the sections.

The Electro-Therapeutical Section contains an interesting paper by Dr. Howard Pirie on "The Disappearance of Enlarged Glands in Lymphadenoma under Treatment by X-rays," followed by considerable discussion.

The Epidemiological Section consists of an elaborate "Contribution to the Study of the Influences determining the Prevalence of Bovine Tuberculous Mastitis."

In the Medical Section is a study, by Dr. J. E. Squire, of "Hospital Infection of Tuberculosis as exemplified by the Records of the Resident Staff of the Mount Vernon Hospital for Consumption for and Diseases of the Chest for the past Fifteen Years." As a result of his inquiries, Dr. Squire believes that "the risk of infection with tuberculosis in a special chest hospital is very small, and is apparently little, if at all, greater than in a general hospital."

The Obstetrical and Gynæcological Section contains a paper on "The Place of Cæsarean Section in the Treatment of Placenta Prævia," and in the discussion the Section as a whole appears to agree with the author in his condemnation of this method of treatment, except in the rarest cases. Dr. Jellett is unable to see in it any advance on our accepted methods.

Sport.

London University Sports.

The Athletic Sports of the University of London were held at Stamford Bridge on June 16th.

As in previous years, Guy's was well represented, and again easily headed the list of schools in the matter of points, scoring 82, King's being second with 33.

In the 100 and 220 Yards Evans was beaten by Haley, of King's, but in the former race just beat Stewart, of the London. The latter race was a record for the meeting, 22⅘ secs.

Fry placed the Mile to our credit after a close race with Mitchell, of Central Technical College. The hurdles was probably the best race of the day, though there were but three starters. At the eighth hurdle O'Kane was leading, but just failed to maintain his form to the last hurdle, and was beaten for second place by Garraway, of University, Renton, our other representative, just winning. Less than a yard separated the three.

Both the jumps went to Guy's. S. H. Browning, without any practice, cleared 5ft. 5in., beating Doorly, of St. Thomas's, by one inch. Sampson won the Long Jump with 20ft. 5½in.

Tucker and Oram were first and second in the Hammer, the former throwing a record distance of 103ft. 4in.

The Three Miles was another great race. At two miles four were far ahead of the others, and of these Fry, Barraclough, and A. P. L. Johnson were Guy's men. At the last lap it was evident that the race lay between Gimson, of University College, and Barraclough, and the former won by five yards in the record time of 16 min. 10⅗ secs.

Guy's won the Tug-of-War, with half their regular team away, beating King's by two pulls to nil. However, one cannot help doubting the word of one of the judges, who spoke of the team as "trained to a gramme," when one considers that Messrs. Pryce-Davies, and Tucker were at the end of the rope. The team consisted of Messrs. Oram, Pryce-Davies, Tucker, Watkin, Browning, Hoby, Moberly, and Mather.

The Relay Race produced the usual excitement. Medlock ran first for Guy's, and finished a few yards behind Stewart, of London. O'Kane easily overtook his man, however, and gave Griffin a comfortable lead. The latter maintained this, and Evans finished first by eight yards. King's were second.

The "Lady Busk" Challenge Cup was won by E. W Haley, of King's, with 30 points. A prize was given for the runner-up, and three men, Messrs. Tucker, Browning, and Fry, all of Guy's, tied with 13 points. The former received it on account of his record with the Hammer.

Amongst the officials there were quite a number of Guy's men.

The following is a full list of results:—

100 YARDS.—E. W. Haley (King's), 1; H. W. Evans (Guy's), 2; W. A. Stewart (London), 3. Time, 10⅖ secs.

220 YARDS.—E. W. Haley (King's), 1; H. W. Evans (Guy's), 2; H. Leete (Univ. Coll.), 3. Time, 22⅘ secs.

440 YARDS.—E. W. Haley (King's), 1; J. C. Brooks (Imp. Coll.), 2; E. W. Cosserat (Cent. Tech.), 3. Time, 54⅕ sec.

HALF MILE.—H. A. Reid (Cent. Tech.), 1; A. D. Openshaw (Birkbeck), 2; H. D. Allen (King's), 3. Time, 2 min. 7⅕ sec.

SHOT.—B. Kinahan (Sch. of Mines), 34ft. 3in., 1; H. M. Read (Birkbeck), 2; W. G. Tucker (Guy's), 3.

HIGH JUMP.—S. H. Browning (Guy's), 5ft. 5in., 1; A. R. C. Doorly (St. Thomas'), 2; E. W. Cosserat (Cent. Tech.), 3.

HAMMER.—W. G. Tucker (Guy's), 103ft. 4in., 1; R. G. Oram (Guy's), 2; S. H. Browning (Guy's), 3.

ONE MILE.—W. K. Fry (Guy's), 1; J. A. Mitchell (Cent. Tech.), 2; J. D. Wells (Birkbeck), 3. Time, 4 min. 53⅘ sec.

THREE MILES.—H. M. Gimson (Univ. Coll.), 1; J. R. Barraclough (Guy's), 2; W. K. Fry (Guy's), 3. Time, 16 min. 10⅗ sec.

HURDLES.—H. F. Renton (Guy's), 1; G. T. Garraway (Univ. Coll.), 2; W. J. O'Kane (Guy's), 3. Time, 17⅗ sec.

LONG JUMP.—B. F. Sampson (Guy's), 20ft. 5in., 1; G. C. Clark (Cent. Tech.), 2; F. J. Gordon (Bart.'s), 3.

RELAY RACE.—Guy's, 1; King's, 2; London Hospital, 3. Time, 1 min. 38⅗ sec.

Cricket.

GUY'S v. STOICS.

This match was played at Honor Oak Park, on June 8th. Guy's won the toss, and went in first on a good wicket. Rook, Digby, and Sampson batted well, and Guy's reached the total of 242. The Stoics, who were two men short, were dismissed for 119, Sampson taking 3 wickets for 11 runs.

GUY'S.

R. Montgomery, c Dalton, b Haywood	13
F. C. Hunôt, c Robertson, b Haywood	8
W. E. S. Digby, c Sedgwick, b Morgan	33
R. M. Veale, c Robertson, b Haywood	4
A. H. Birks, c Robertson, b Morgan	12
A. F. Rook, b Robertson	63
R. S. Kennedy, b Haywood	11
B. F. Sampson, b Morgan	39
A. H. Harkness, b Robertson	8
J. E. Rhys Evans, b Robertson	12
C. E. Rice, not out	7
Extras	32
Total	242

THE STOICS.

C. E. Dalton, b Rice	1
N. E. Farr, c Veale, b Rice	8
H. J. Tilly, b Rice	53
Chas. Haywood, b Digby	6
D. Robertson, b Rhys Evans	39
C. H. Sedgwick, b Sampson	1
Chris. Haywood, not out	6
F. J. Morgan, b Sampson	0
E. N. Evans, b Sampson	2
Extras	3
Total	119

GUY'S v. ST. THOMAS'S.

INTER-HOSPITAL CUP TIE.—First Round.

This match was played at Honor Oak Park on June 9th. Guy's won the toss and went in first on a fast wicket. Montgomery played a superb innings of 90. He went in first and was last man out, having batted very patiently throughout. Both Kahlenberg and Digby bowled well, the former taking 6 wickets for 46 runs, and the latter 4 for 43.

GUY'S.

M. M. Munden, c Johnstone, b Morcom	4
R. Montgomery, c Meakin, b Bowes	90
B. Blackwood, b Morcom	3
A. H. Birks, b Morcom	26
W. E. S. Digby, c Fry, b Meakin	9
A. F. Rook, c Paddon, b Bowes	18
F. C. Hunôt, b Bowes	1
R. M. Veale, b Paddon	4
R. S. Kennedy, b Meakin	16
F. Kahlenberg, c & b Morcom	14
B. F. Sampson, not out	0
Extras	16
Total	201

ST. THOMAS'S.

L. Meakin, b Digby	25
R. F. B. Bowes, c Birks, b Kahlenberg	4
A. F. Morcom, b Kahlenberg	30
D. M. Gibson, b Kahlenberg	6
E. A. Seymour, b Digby	4
H. L. Mann, c Birks, b Kahlenberg	6
W. L. Johnstone, b Digby	7
L. W. Shelley, b Kahlenberg	9
E. H. Walker, c Veale, b Digby	0
H. J. B. Fry, b Kahlenberg	11
H. L. Paddon, not out	4
Extras	7
Total	113

GUY'S PRESENT v. PAST.

Played at Honor Oak Park on June 11th, on a very wet wicket. The Past, whose ranks were swelled by a number of Present men, went in first, and compiled 202. The Present were only able to reach 160, thus losing by 42 runs.

PAST.

J. N. Bartlett, b Harkness	37
F. Morres, b Rice	41
R. C. Poyser, c Munden, b Harkness	13
C. H. Fagge, c Birks, b Montgomery	30
H. D. Wyatt, c Blackwood, b Rice	0
W. T. Clarke, b Rice	17
L. C. D. Irvine, c Birks, b Montgomery	3
H. C. Rook, c Montgomery, b Hunôt	7
E. S. Bowes, b Rice	21

V. R. Glendining, not out	18
A. E. Leviseur, c Blackwood, b Rice	2
Extras	21
Total	210

PRESENT.

M. M. Munden, b Bartlett	26
A. F. Rook, c Wyatt, b Poyser	13
A. H. Birks, c Clarke, b Bartlett	9
R. M. Veale, run out	31
R. Montgomery, c Morres, b Bartlett	5
B. Blackwood, b Wyatt	2
F. C. Hunôt, b Bartlett	41
B. F. Sampson, b Morres	18
A. H. Harkness, b Clarke	6
C. E. Rice, run out	1
W. E. Fox, not out	1
Extras	7
Total	160

GUY'S v. R.A.M.C.

This match was played at Aldershot on June 15th, Guy's winning by 106 runs. The wicket was slow, and Guy's made 259. Montgomery, Harkness, and Rook batted well, the last named hitting three 6's. The Guy's fielding was exceptionally good.

GUY'S.

M. M. Munden, b Mack	11
R. Montgomery, b Mack	55
A. H. Birks, b Stroud	27
R. M. Veale, c Fish, b Brunskill	14
W. E. S. Digby, st Fish, b Mack	19
A. H. Harkness, b Bostock	42
W. Harris, c Fish, b Mack	14
A. F. Rook, c Stroud, b Bostock	63
F. C. Hunôt, c Bostock, b Mack	0
R. N. Curnow, c Fish, b Bostock	0
J. E. Rhys Evans, not out	1
Extras	13
Total	259

R.A.M.C.

Capt. Bostock, c Digby, b Curnow	16
Corp. Fish, c Harkness, b Curnow	36
Serg. Stroud, b Curnow	4
Lieut. Kernahan, c Montgomery, b Harris	1
Capt. Brunskill, c Montgomery, b Harris	29
Capt. Greenwood, c Munden, b Digby	9
Pte. Prince, lbw, b Harris	11
Lieut. Sheppard, b Digby	0
Capt. Gray, c Rook, b Curnow	5
Pte. Mack, run out	13
Corp. Keeble, not out	3
Extras	26
Total	153

GUY'S v. BICKLEY.

Played at Bickley on June 17th. Guy's had a very weak side out, but started well, having secured 4 wickets for 38 runs. A series of mistakes in the field then commenced, Earnshaw being missed once, and Osborne three times. This partnership put on 126 runs for the fifth wicket.

BICKLEY.

A. E. Earnshaw, b Curnow	69
J. W. Willett, c & b Harris	3
R. Bruce Hall, c Hunôt, b Curnow	12
A. L. Mark, b Harris	0
C. L. Gregory, lbw, b Harris	2
Rev. S. E. Osborne, c Gibb, b Harkness	75
B. Batchelor, c Harkness, b Harris	27
P. R. Nelson, b Harris	33
E. P. Nicholls, b Harris	4
E. A. Willett, c Bowes, b Munden	14
L. Jackson, not out	4
Extras	26
Total	269

GUY'S.

M. M. Munden, c Earnshaw, b Willett	26
W. Harris, c & b Gregory	9
R. Curnow, b Gregory	9
A. H. Harkness, c Bruce Hall, b Willett	1
F. C. Hunôt, c Jackson, b Willett	16
R. M. Veale, b Batchelor	27
G. Dinan, b Osborne	6
E. S. Bowes, c Mark, b Osborne	4
R. S. Stewart, not out	12
C. Gibb, c Mark, b Osborne	2
H. B. Neely, b Batchelor	5
Extras	2
Total	119

GUY'S v. GRANVILLE (LEE).

Played at Lee on June 18th. Guy's went in first on a perfect wicket, but their batting broke down in an astonishing manner. The Granville passed the Guy's score with five wickets down.

GUY'S.

M. M. Munden, c Platt, b Johnston	11
R. Montgomery, b Johnston	17
A. H. Birks, b Johnston	22
B. F. Sampson, c Johnston, b Spencer	4
F. C. Hunôt, b Lowis	10
A. F. Rook, lbw, b Johnston	31
A. H. Harkness, c Lowis, b Johnston	17
G. Archer, b Spencer	10
R. Curnow, hit wkt, b Johnston	0
A. Lewis, not out	0
C. E. Rice, b Johnston	4
Extras	15
Total	141

GRANVILLE.

F. E. Lander, c Harkness, b Curnow	15
Major Lowis, b Harkness	50
S. Platt, c Curnow, b Harkness	7
C. E. C. Kendle, b Curnow	23
J. A. Gravett, lbw, b Harkness	0
A. S. Johnston, c Birks, b Munden	41
P. P. Lincoln, c Rook, b Hunôt	34
G. Beasley, c Birks, b Munden	3
A. D. Spencer, not out	24
P. C. Wood, b Birks	12
P. L. Lincoln, c Sampson, b Rice	24
Extras	6
Total	239

Lawn Tennis.

GUY'S 1ST VI. v. BALLIOL COLLEGE, OXFORD.

This match took place at Oxford on Saturday, June 11th, and resulted in a win for the hospital by five matches to four. W. R. Reynell, captain of Oxford last year, who is coming up to Guy's we are pleased to hear, turned out against us. Result:—

H. W. Barber and R. Curle lost to W. R. Reynell and E. N. Blandy, 1–6, 3–6; lost to R. Wingate and N. S. Macdonnell, 7–9, 6–2, 4–6; beat Vlieland and Rashid, 6–1, 6–3.

G. C. Covell and A. Zorab beat Wingate and Macdonnell, 6–4, 6–1; beat Vlieland and Rashid, 6–1, 6–1; lost to Reynell and Blandy, 4–6, 7–5, 6–8.

A. S. Roe and E. P. Poulton beat Vlieland and Rashid, 6–2, 6–2; lost to Reynell and Blandy, 4–6, 4–6; beat Wingate and Macdonnell, 6–3, 4–6, 6–3.

GUY'S 2ND VI. v. HERTFORD COLLEGE, OXFORD.

This match was played at Oxford on Saturday, June 11th, when the hospital were beaten by five matches to four. Result:—

H. L. S. Griffiths and R. H. Lucas beat Garratt and Hunter, 6–2, 5–7, 6–2; beat Clerke and Light, 4–6, 6–2, 6–3; beat Krigler and Durnford, 6–3, 6–0.

G. W. King and W. J. D. Smythe lost to Clerke and Light, 2–6, 2–6; lost to Garratt and Hunter, 3–6, 2–6; lost to Krigler and Durnford, 6–1, 4–6, 5–7.

G. R. Hinde and W. E. S. Digby beat Krigler and Durnford, 6–3, 6–8, 6–4; lost to Garratt and Hunter, 3–6, 3–6; lost to Clerke and Light, 5–7, 2–6.

Draw for Inter-Hospital Cup, June 27th and 28th, at Chiswick Park: London v. Guy's, Bart.'s v. St. Thomas's.

R. CURLE'S VI. v. HILL L.T.C., WIMBLEDON PARK.

This match was played at Wimbledon, and resulted in a win for the home club by five to four. Result:—

R. Curle and H. W. Barber beat C. E. Harrison and T. Morewood, 6–1, 7–5; beat A. W. Andrews and F. Howett, 6–2, 10–8; lost to E. Dowsett and A. Paton, 4–6, 3–6.

G. C. Covell and H. L. S. Griffiths lost to Andrews and Howett, 0–6, 3–6; beat Harrison and Morewood, 1–6, 6–3, 6–1; beat Dowsett and Paton, 9–7, 3–6, 7–5.

H. S. Groves and L. Price Harris lost to Dowsett and Paton 3–6, 3–6; lost to Harrison and Morewood, 1–6, 2–6; lost to Andrews and Howett, 0–6, 5–7.

GUY'S 1st VI. v. KENT.

This match was played at Honor Oak Park on Saturday, June 18th, and resulted in a win for the hospital by five matches to four. Result:—

G. C. Covell and H. W. Barber beat W. Dunn and C. E. Cousins, 6–2, 4–6, 6–1; lost to Captain Bishop and R. F. Heelus, 3–6, 4–6; beat L. J. Osmond and E. A. Osmond, 6–3, 6–4.

R. H. Lucas and H. L. S. Griffiths lost to Bishop and Heelus, 5–7, 6–2, 3–6; beat Osmond and Osmond, 6–2, 6–4; beat Dunn and Cousins, 6–2, 6–1.

H. S. Groves and G. W. King beat Osmond and Osmond, 6–2, 6–2; lost to Bishop and Heelus, 6–8, 0–6; lost to Dunn and Cousins, 3–6, 6–1, 4–6.

Birth.

WETHERELL.—On June 16th, at The Old House, Ipswich, to Dr. and Mrs. Wetherell, a son.

Marriages.

HOPKINS—WILBERFORCE.—On June 9th, at St. Oswald's Church, Fulford, York, by the Rev. W. B. Leighton Hopkins, M.A., Rector of Lavenham, brother of the bridegroom, assisted by the Rev. Canon John Watson, M.A., Sub-Dean of York Minster, and the Rev. T. E. B. Guy, M.A., Vicar of the parish, Charles Leighton Hopkins, B.A., M.B., B.C. Cantab., Medical Superintendent, York City Asylum, son of the late Canon Hopkins, B.D., Vicar of Littleport, Ely, and of Mrs. W. Bonner Hopkins, St. Leonards-on-Sea, to Hilda, daughter of the late W. W. Wilberforce, Millfield, York, and Mrs. Wilberforce, Fulford, York.

KENT—LLOYD.—On the 21st June, at St. Bueno's Church, Berriew, by the Rev. W. J. Morton, Hugh Braund Kent, M.B., B.S. Lond., M.R.C.S., L.R.C.P., to Margaret Mary, second daughter of Edward Lloyd, Esq., of Berriew, Montgomery.

LACEY—FRENCH.—On June 2nd, at St. John's Church, Penge, by the Rev. W. Smyly, Hugh K. Lacey, of Torquay, eldest son of T. Warner Lacey, M.D., to Annie Louisa (Cissi), eldest daughter of Mr. and Mrs. John French, of Sydenham.

PRIDEAUX—HOUSE.—On May 31st, at St. Mary's Church, Powerstock, Dorset, by the Rev. R. W. H. Dalison, M.A., Rector of Stone, Greenhythe, Kent, assisted by the Rev. W. F. Rickman, M.A., Vicar of Powerstock, and the Rev. E. J. Tadman, M.A., Albert E. D. Prideaux, L.D.S. Eng., youngest son of the late W. S. Prideaux and of Mrs. Prideaux, of Wellington, Somerset, to Edith M. A. House, only daughter of Tom House, of Powerstock, Dorset.

Deaths.

PEAKE.—On June 5th, at Homefield, Platt's Lane, Hampstead, William Harland Peake, M.D., B.S., aged 40 years.

SALMON.—May, 1910, at Falmouth, Charles Arthur Craven Salmon, L.S.A.

Ed.—A. N. C.

GUY'S HOSPITAL GAZETTE.

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Our New President.

MR. H. COSMO O. BONSOR, who succeeds the present King in the office of President of Guy's Hospital, was born at Polesden, Surrey, on September 2nd, 1848, and was educated at Eton. A man of vast public activity, he has been Chairman of the South Eastern Railway since 1898, is Chairman of Watney & Co., sat as Member of Parliament for Wimbledon from 1885 to 1900, and is a Director of the Bank of England. His connection with Guy's Hospital began in 1882, when he was appointed a Governor, and from then until the present time he has devoted his financial genius untiringly and whole-heartedly to its service. Appointed Treasurer in October, 1896, he found the Hospital finances in a truly deplorable condition, and their restoration to the condition in which they are to-day represents a great and remarkable piece of work in the cause of charity.

When Mr. Bonsor entered upon his duties, one hundred and fifty beds in the Hospital were closed to the sick poor for want of funds, and the annual revenue had fallen from £40,000 to £20,000. To meet this financial collapse the Re-endowment Fund was started, with the late King Edward VII. at its head, and at the Festival Dinner which inaugurated it nearly £170,000 was received, while at the present time the Fund totals £305,000. In the twelve years during which Mr. Cosmo Bonsor has administered our finances the average annual income of the Hospital has increased by the sum of nearly £54,000. Great as are these improvements in revenue, even greater are the structural alterations which have been carried out, including as they do the renovation of all the wards and buildings, the construction of theatres and the building of a new Out-patient Department, an Actinotherapeutic Department, a model laundry, and a central light, heat and power station. To meet these improvements the sum of £350,000 has been raised and spent, at a total cost of only 4·9 per cent. of that amount, which is eloquent testimony to the value of having a capable business man at the head of affairs. The keynote of his administration has been economy and efficiency, and his association with Sir Cooper Perry as Superintendent, and Mr. J. H. T. Woodd as Surveyor, has been one eminently conducive to such a policy.

Mr. Cosmo Bonsor has ever been the friend of the students of the Hospital, and all who have attended his garden parties at Kingswood Warren during the last ten years know and appreciate his hospitality, while the Gold Medals in Medicine and Surgery and the prize for the Physical Society show his interest in academic matters. While we regret his loss as Treasurer, we welcome him as President, and trust he may give the Hospital the benefit of his interest and genius for many years to come.

The Rt. Hon. VISCOUNT GOSCHEN, who succeeds Mr. Cosmo Bonsor as Treasurer of the Hospital, was educated at Rugby School and Balliol College, Oxford. He is president of the London County and Westminster Bank, and is the son of the first Viscount Goschen, who was Chancellor of the Exchequer under Lord Salisbury, and who, it will be remembered, distributed the prizes at the Hospital in 1904. Viscount Goschen was appointed a Governor in 1903, and since then has taken great interest in the working of the Hospital and has regularly attended the meetings of the House Committee. He becomes Treasurer at a time when there are numerous alterations to be undertaken, but we feel sure that the responsible and onerous duties attaching to the post will be safe in his hands.

Calendar of Coming Events and Ensuing Take-in Weeks.

July.

Sat. 9. Cricket—2nd XI. v. L. & S.W. Bank (Away).

Mon. 11. Second part of Conjoint D.P.H. Examination begins.
First M.B. London Examination begins.
Clinical Lecture by Mr. Ormond (Ophthalmology), 1.15 p.m.

Thur. 14. Second Examination for M.B. London (Part I.) begins.
Messrs. Symonds and Steward's Take-in (Messrs. Evans and Saner).

Fri. 15. Examinations for final M.B., and for M.D. and M.S. Durham begin.

Sat. 16. Cricket—1st XI. v. Beckenham (Home).

Mon. 18. First Conjoint Examination begins.
Clinical Lecture by Dr. Hertz (Electrotherapeutics), 1.15 p.m.

Thur. 21. Messrs. Lane and Fagge's Take-in (Messrs. Mills and Kahlenberg).

Fri. 22. Summer Session ends.

Passim.

At a General Court of the Governors held on Friday, July 1st, the following Governors were present: Mr. Cosmo Bonsor, Lord Cottesloe, Viscount Cross, Viscount Goschen, Lord Revelstoke, Hon. Sir Chas. Fremantle, Sir Cameron Gull, Bart., Sir Joseph Dimsdale, Bart., Sir Herbert Tree, Mr. Seton-Karr, Col. Curtis-Hayward, Mr. John Gladstone, Mr. Benyon, Mr. Norman, Mr. Robert Gordon, Mr. Campbell, Mr. Lafone, Mr. Chas. Hoare, Mr. Whitbread, Mr. Abel Smith, Col. Lucas, Mr. H. H. Raphael, M.P., Mr. Vincent Vickers.

His Majesty the King, having been pleased to accept the office of Patron of the Hospital, Mr. Cosmo Bonsor was proposed for the office of President by Viscount Cross, seconded by Lord Revelstoke. and elected unanimously. A vacancy being thus caused in the Treasurership, Mr. Cosmo Bonsor proposed, and Mr. Norman seconded, the Rt. Hon. Viscount Goschen, who was thereupon unanimously elected as Treasurer of the Hospital. It is understood that the result of the Court was communicated to the King by Mr. Bonsor, and that His Majesty has been graciously pleased to express his satisfaction at the choice of the Governors.

Congratulations to the following gentlemen on their new appointments:—Demonstrator of Anatomy: Mr. Layton. Surgical Registrar: Mr. Townrow. Ophthalmic Assistant: Mr. Zorab, and Resident Surgical Officer: Mr. Trethowan.

We regret to record the death of Mr. Leopold Burroughs, M.R.C.S., L.R.C.P., of Eltham Road, Lee, at a Nursing Home in London on June 14th. Mr. Burroughs qualified in 1884, and afterwards held the posts of Resident Obstetrician and House Surgeon at Guy's Hospital. He was a Surgeon to St. John's Hospital, Blackheath, and his death will be lamented by a large circle of friends and patients.

IT is with deep regret that we have to record a serious accident to Mr. W. W. Cook. The following is from the Norwich *Evening News* of June 25th :—

> About 5.30 yesterday afternoon a most painful accident happened in the process of haymaking at St. Faith's on Mr. W. W. Cook's land, adjoining the main road between Norwich and Horsford. From information at present obtainable, it appears Dr. Warner Cook, who has just completed a brilliant career at Guy's Hospital, and was taking a brief holiday in the country, was standing in front of the grass cutter, when the horses suddenly started, and before he could clear himself his right leg was terribly cut just above the ankle. Mr. A. Steward Cook was close at hand, and, seeing how seriously his brother was injured, immediately motored for Dr. R. J. Horn, who was quickly in attendance, and rendered what aid he could in the open field. The sufferer was subsequently placed upon a hurdle and carried by some workmen to the road, where he expressed the desire to be taken to the Norfolk and Norwich Hospital. Dr. Cook is immensely popular in the neighbourhood. During his vacations he has mixed freely with all classes in his native village. It may be mentioned that this sad accident has happened on his 27th birthday.
>
> On inquiry last night at the hospital we were informed that Dr. Cook's condition was as satisfactory as could be expected.

We understand that Mr. Cook is at present progressing favourably, and we offer him our best wishes for a speedy and complete recovery.

AT the Annual Public Meeting of the Hospital Saturday Fund, held at the Mansion House on April 16th, Mr. Montagu F. Hopson moved: "That this meeting approves of the action of the Hospital Saturday Fund in providing assistance to those needing dental treatment." After stating that the condition of the people's teeth was bad, and that the results of that condition were also bad, and adducing arguments in support of both these contentions, the speaker pointed out the many ways in which dental disease was now being successfully combated. He appealed particularly for more complete prophylaxis, and emphasised the importance of providing dental treatment for children between the ages of four and fourteen, "the most critical period in an individual's dental history." After referring to the work done by the Royal Dental, the National Dental, and Guy's Hospital, and pointing out the difficulty in providing an adequate supply of artificial dentures, Mr. Hopson praised the manner in which the Hospital Saturday Fund's Dental Department was administered, and expressed the hope that its benefits might be more fully realised and extended in the future.

WE have to congratulate the Shooting Team and the First and Second Lawn Tennis VI.'s on winning their respective Inter-Hospital Cup Competitions, and we hope that before our next issue is published the Water-Polo and Cricket Cups may have been added to the collection which already adorns the Club Smoking-room.

THE Residents' going-off dinner was held on the 30th of last month, and was a very successful termination to Mr. Mullins' term of office as President. The business of the evening resulted in the election of Mr. T. Evans as the new President, and Mr. T. F. Brown as the new Vice-president of the Residents. Mr. Evans, on whom the mantle of Mr. Mullins thus falls, will make a smaller mark for bread-throwing, but it is certain that he will make a very popular President, "indeed yes"; and he will have a worthy right-hand man in Mr. Brown, who continues a line of Colonials who have held office at the Residents' table. The level of the oratory at the dinner was much as usual on these occasions, but the speech of Mr. Mills, who replied to the toast of the "On-coming Residents" was distinctly above the average, for he sounded the deeper note, which is in everybody's mind, but is seldom so well expressed. It is, indeed, with feelings of profound regret that the men at the hospital (and we are confident we may add the Staff and the nurses as well) part with Mr. Mullins, who has been one of the most popular men at Guy's during the last few years. And with him we lose Mr. Lucey, the late Vice-president, and Messrs. Basker and Greenwood. Mr. Townrow, however, as everyone was glad to hear, will remain among us as Surgical Registrar. While the various speakers were collecting their thoughts, or, rather, selecting the thoughts which they desired to express, a number of songs, nearly all old favourites, were sung by Messrs. Bodkin, Blake, Evans, Johnson,

and Mullins to the accompaniment of Mr. Jarvie.

THE text of Sir William Collins' Bill to amend the law relating to Coroner's Law, and the Certification and Registration of Deaths and Burials, has just been published. This Bill embodies many of the recommendations of the Departmental Committee on Coroners' Law of 1908, and the Deaths Certification Committee of 1893, and contains many desirable and much-needed reforms. In the section on Coroners, their districts, payment, retirement and superannuation are re-arranged, while the appointment is limited to practising barristers or solicitors of not less than five years' standing, or to medical practitioners who are also barristers or graduates of law. A Coroner may, under this Bill, hold an inquiry, including a post-mortem examination, without necessarily having an inquest, and the farce of "viewing the body" by the jury is by it made no longer compulsory. Arrangements are made for the appointment of skilled pathologists to assist the coroner in his inquiries, while the scale of medical witnesses' fees is also to be reconstructed.

IN the section dealing with the registration of deaths it is made compulsory for a qualified medical man to inspect and identify the body, and he has also to certify to the fact of death as well as to its cause. Further, "any dead child which has issued from its mother after the expiration of the twenty-eighth week of pregnancy, whether alive or dead, shall be the dead body of a person within the meaning of the Coroners Act, 1887, and this Act, and a person within the meaning of the Births and Deaths Registration Act, 1874." It will be seen that the Bill contains many and important alterations of the law as it at present stands, and opinions will of necessity differ as to the need or desirability of some or all of them. The appointment of skilled pathologists is a further step in the direction of that specialism which, although conducive to the advance of our profession as a whole, yet makes the already hard life of the general practitioner still harder, and is bound to meet with some opposition; while the limitation of the appointment of Coroner to gentlemen having a legal qualification is an even more controversial matter. Whether a Coroner should be primarily a medical man or a lawyer is a matter of some difficulty to decide, but the law would, in the former case, certainly be interpreted more according to its spirit and less according to its letter than in the latter, which, in the business usually met with in Coroners' Courts, seems desirable.

WE have received a copy of the June number of our new contemporary the *University College Hospital Magazine*, and extend a hand to it in welcome and congratulation on its first appearance. If the standard of the present number is maintained we predict for it a long and prosperous voyage on the sea of journalism, with a straight course, a full cargo, and an able and willing crew.

THERE has recently been placed in the Medical School buildings a Chinese Temple bell, the gift of an old Guy's man. A brass plate bearing the following inscription :—

> "Chinese Temple bell, Shantung Province, presented to Guy's Hospital by Fleet-Surgeon C. M. Beadnell, R.N., H.M.S., *King Alfred*,"

is affixed to the wall beneath. The bell, which is three feet in height and eight feet in circumference, was originally captured during the last Boxer trouble, and was presented to the donor. As to the adventures hidden by the word "captured" we can only guess, but by its position next to the Anatomy Theatre, the bell provides that touch of romance which is needed to counterbalance the Physiological Theatre on the opposite side.

THE Committee of the Rugby Football Club Ball, which was postponed owing to the death of King Edward VII., ask us to state that it will be held at Prince's Galleries on Monday, October 24th. Tickets, price 12s. 6d. (including supper), may be obtained from the Hon. Sec. J. G. Saner, and it is hoped that men will help, by being present, in making the dance a success.

As we go to press, the Garden Party, of which full details will be published in our next issue, is in progress. Despite a rather gloomy day and a back-ground of scaffolding, the Park contrived to look gay in its motley, and our usually somewhat sombre hospital was brightened by the crowds of gaily-dressed visitors who passed through its wards and departments. The music of the Royal Meister Orchestra, which played during the proceedings, was much appreciated, and contributed to the success of a very enjoyable afternoon.

Reviews, etc.

Books for review should be addressed to The Editor, Gazette Office, Guy's Hospital, S.E. Their price should in every case be stated.

The Dental Directory, 1910. Compiled from official sources. (John Bale, Sons & Danielsson, Ltd.) Price 2s. 6d. net.

In reviewing the first edition of this book, we recommended that, in future, the names of the medical and dental schools where each practitioner had received his professional education should be appended. We are glad to see that in this edition this improvement has been made. Also several others; practitioners' telephone numbers are given, and a new list of the leading dental dealers and depôts, with their telegraphic addresses and telephone numbers, has been compiled and should prove distinctly useful.

It may be pointed out that this little book of reference is of use to *medical* practitioners, in view of the important resolution passed by the General Medical Council in 1898:—"Any registered medical practitioner who knowingly and wilfully assists a person who is not registered as a dentist in performing any operation in dental surgery, either by administering anæsthetics or otherwise, will be liable, on proof of the facts, to be dealt with by the General Medical Council as having been guilty of infamous conduct in a professional respect."

Papers, etc., Received.

Chronic Interstitial Otitis, by W. Sohier Bryant (The Laryngoscope).

THE EDITOR will, at all times, be glad to consider articles or sketches, provided that they are accompanied by the writer's name and address, not necessarily for publication. Payment is a matter of arrangement, and the fees that the GAZETTE *can offer are merely nominal, but if the writer desires any remuneration that fact should be stated. Authors who desire reprints of their papers should make their own arrangements with the printers when they return their proofs.*

Annual Report of the Chapel Committee for year ending Easter, 1910.

THE Chapel Committee have pleasure in presenting the following report for the year ending Easter, 1910:—

There has been no alteration in the ordinary chapel services.

In September last Mr. H. Depree resigned his Organ Scholarship, having held it for one year only. In the same month, on the resignation of Mr. H. Taylor after many years of painstaking and devoted work, Mr. Clive Carey, Mus.Bac., of Clare College, Cambridge, was appointed Organist and Choir-master.

Mr. Carey has thrown himself into his work with zeal, and there has been a marked increase in the average attendance of the members of the students' choir. At both the Christmas and Easter Festivals special music was sung at the close of the evening services. On Good Friday evening a service was held in chapel, at which parts of Bach's Passion according to St. Matthew were sung, and the reverent and devotional rendering of the music makes us hope that this service will be repeated another year.

On the evening of Friday, February 11th, the Lord Bishop of Woolwich held a confirmation in the chapel, at which seventeen candidates were presented; this is the first confirmation to take place in the chapel for some eight years. We regret that our Chaplain, the Lord Bishop of Southwark, was prevented, by his absence in India, from coming to us in Lent, but we hope that we may shortly have the pleasure of an official visit from him.

The intention expressed of adding the name of the late Dr. Horrocks to the list on the walls of the chapel has been carried out. The House Committee have also placed a brass tablet on the east wall to the memory of the late Mr. Marcus Trevelyan Martin, a Governor of the hospital from 1899 till the time of his death in 1908.

The committee desires to express its grateful thanks to the Clergy who kindly preached at the Special Advent, Lent, and Guild of S. Barnabas services, and also to the College of S. Saviour for their occasional help.

Pass List.

University of Cambridge, June, 1910.

THIRD EXAMINATION FOR MEDICAL AND SURGICAL DEGREES.

PART II.—SURGERY, MIDWIFERY AND MEDICINE.

The following have now satisfied the examiners in all three sections:—

H. L. Attwater, Pemb. | K. T. Khong, John.
G. W. Dryland, Caius. | E. R. Stone, Emm.
W. E. Wallis, Clare.

The Biennial Dinner.

"Dr. Middleton misdoubted the future as well as the past of the man who did not, in becoming gravity, exult to dine. That man he deemed unfit for this world and the next."—*The Egoist.*

THE Connaught Rooms, where the Biennial Dinner was held on July 1st, would have presented a pleasing sight to the good *gourmet* Dr. Middleton, on that evening, for everyone who was present exulted to dine; not so much for the physical pleasure of eating and drinking, which perhaps was chiefly in the doctor's mind, though the excellent *menu* ensured that, too, but because everyone there met on the common ground of affection for Guy's Hospital and School. Over three hundred men who regard Guy's as their *Alma Mater* gathered there to do her honour, and to meet both the men of their own year and those who preceded and have followed them.

To one who, on that occasion, gained his first experience of a Biennial Dinner, it was an inspiring thought that all these men regarded Guy's with a similar affection, and that some of them had met in every other year for longer than they might care to confess, to renew old acquaintanceships and to revive old memories centreing round that "most noble Public Charity and admirable Medical Establishment, Guy's Hospital," to quote the title to an excellent old print of the hospital, which was reproduced on the cover of the list of diners.

It was a real pleasure to see again veterans of the Consulting Staff who qualified sixty years ago, like Mr. Bryant and Dr. Pavy; to see a comparative youngster like Mr. Golding-Bird surrounded by a party of his old house-surgeons and dressers, telling stories in his own inimitable manner; others, like Dr. Savage and Mr. Higgens and Mr. Durham and Dr. Goodhart, who are unfortunately seldom seen at the hospital now; and some, like Dr. Starling, Dr. Stevens, Dr. Spriggs, Mr. Handley, Mr. Tubby, and Dr. Forsyth, whose spheres of action lie elsewhere than at Guy's, but who, nevertheless, re-unite in praise of the old school to which they are such a credit.

In the reception room was such a babble of voices as is commonly supposed to be a monopoly of the other sex, and there was gossip, too! Changes in personal appearance caused by the ravages of time are always so interesting to a man who is conscious of showing them himself. "If I *am* more than a little thin on the top, so that the barber has long ceased to comment on it," he may think, "well, there is ———, who qualified the same year as I did, with more grey hairs than he has time to count, and he has grown more important-looking about the waistcoat, too, by Jove!"

The younger men have altered less in appearance than in circumstances. Their talk is of the state of practice, and who has got married, and how many children the other man has. Men still at the hospital look forward rather than back, and wonder how many biennial dinners it will be their good fortune to attend in the future, and what success will be theirs, and who will be on the Staff then.

* * * *

The splendid new Connaught Rooms were found to be admirably adapted for such a gathering. The plan of arranging contemporaries to sit together at a number of small tables, each presided over by a vice-chairman—which, with other innovations, was initiated with entire success by Dr. Shaw at the dinner in 1908—was again adopted. On this occasion, thirty small tables, each seating from eight to twelve diners, were provided. Dr. Hale White presided over the assembly, and announced that he was sending a telegram to Mr. W. W. Cook, whose unfortunate accident is recorded in "Passim." He also announced that telegrams, expressing regret at their inability to attend, had been received from Messrs. J. Rand (Surbiton), Ewart (Eastbourne), W. H. Fisher (Fakenham), Gough (Compton Martin), Cotton, Lavers (Bath), A. C. Roberts (Eastbourne), Brogden (Ipswich), Newnham (Clifton), Leslie Bates (St. Albans), and G. N. Bartlett (Bexley).

In accordance with the custom now established, there were no speeches. Dr. Hale White submitted the loyal toast, and Mr. Cosmo Bonsor that of the chairman, which was received with musical honours. The toast of "Guy's Hospital and School" was preceded by the singing of "Auld Lang Syne."

Dr. Hale White also proposed the health of Dr. Fawcett, who has acted as the Honorary Secretary for the dinner, and has carried all the arrangements through with conspicuous success. How much time and patience must necessarily be expended on the arrangements for such a gathering, probably only one who has himself undertaken them can fully appreciate, but it is evident to anybody that it must be very great. Dr. Fawcett is to be congratulated on the success of a very enjoyable dinner; and many will now look forward to the year 1912!

American Surgeons' Visit to Guy's Hospital.

THE party of members of the American Society of Clinical Surgery who are at present in England visited Guy's on Monday, July 4th. Included among them were Dr. Chas. Mayo, the younger of the two brilliant brothers who have made Rochester world-famous in the annals of surgery; Dr. Crile, whose work, both as surgeon and physiologist, is equally well-known, and Dr. Murphy, celebrated, amongst other things, as the inventor of the "button" known by his name.

The visitors arrived early, and at 8.30 a.m. Mr. Arbuthnot Lane began operating. The first case was one of chronic intestinal stasis, for the relief of which an ileo-sigmoidostomy and colectomy were undertaken.

A. N., single woman, æt. 49. Five years' history of abdominal pain and discomfort. She was not very constipated previous to this time, but had suffered a good deal from headaches, which were worse at her menstrual periods. At Easter, 1905, she began to have attacks of abdominal pain which became very acute, and she was operated on at Northampton Hospital for appendicitis. She did not regain health after this operation, and the pain recurred and prevented her walking. She had much nausea. In October, 1905, she was operated on for cystic degeneration of the breast, and in January, 1906, her right breast was removed for the same cause. Her abdominal pain recurred, and she was very constipated and in bed for three months, from which she was removed to hospital to have a cyst removed from her left breast. She has lost a lot of weight. Condition on admission.—Patient looks thin, ill and old. Her abdominal pain is acute and accentuated on moving, and never leaves her; she cannot take solid food owing to the pain and nausea it causes. Hands and feet are cold and damp and axillæ very pigmented. Abdominal palpation causes much pain. She was given bismuth and skiagraphed, and the passage through the large intestine was found to be delayed (four days) although not obstructed at any point.

The patient was infused with saline both before and during the operation, since the experiments of Dr. Crile have shown that, provided the blood-pressure be raised above normal by infusion, the severest surgical measures can be undertaken without producing that fall of pressure which constitutes "shock." Mr. Rowell anæsthetized, the anæsthetic being ether given by the open method. The visitors were also shown three cases who had previously had colectomies performed on them, and expressed themselves as delighted at the results.

Mr. Lane's next operation was on a spiral fracture of the femur in a child, which he plated after his usual manner. On the desire of the Americans to see more bone work, two more cases of fracture were operated on, one an adduction fracture (vertical fracture of the internal malleolus and transverse fracture of the fibula), and the other a case of fractured patella.

In Mr. Symonds' theatre the visitors saw an operation on a case of pyloric obstruction which had had a previous gastro-enterostomy performed. The opening was found to be closed, and a Murphy's button was inserted beside it. It is worthy of note that Mr. Symonds was the first surgeon to use one of the buttons in England. They also saw an old case of frontal sinus suppuration and resultant necrosis of bone, in which Mr. Symonds had removed the greater part of the frontal bone, the walls of the orbit, and the malar with remarkably little deformity.

Dr. Crile, in an interview, stated that he and his fellow surgeons had been much impressed and interested with what they had seen so far during their visit to England, and that one of the most profitable mornings he had spent was the one at Guy's. He expressed admiration for Mr. Lane's work, which he remarked had many followers in America.

In regard to the treatment of simple fractures by operation, Dr. Crile said that this line of treatment was just beginning to be taken up in America, and would, no doubt, receive an impetus from what they had seen at Guy's. Some of the visitors, with Mr. Symonds, Mr. Lane, and Mr. Rowell, were afterwards entertained at lunch in the College by the Residents.

Change of Address.

John Atkins, M.B. Lond., F.R.C.S. Eng., from 59, Addison Gardens, Kensington, W., to 12, Kensington Gore, W.

R. Davies-Colley, M.C., F.R.C.S., to 48, Brook Street, W.

W. M. Mollison, M.C., F.R.C.S., to 48, Brook Street, W.

Richard Roberts, L.D.S. Eng., from 2, Tub's Hill, Sevenoaks, to "Kendal," Pembroke Road, Sevenoaks.

A. M. A. Stevens, L.D.S. Eng., from 11, Clapham Park Road, S.W., to 38, South Side, Clapham Common, S.W.

(The Editor will be very glad to receive a postcard with notes of any change of address.)

Nursing News.

Matron's Office.

On June 1st, Sister Millicent, Miss Farrow, the Second Home Sister, left the Hospital to be married. Sister Eleanor, Miss Jolley, who has been acting as Surgical Night Sister *pro tem.*, was transferred to the Nurses' Home, and Miss Margaret Hogg, who completed her training in July, 1908, and has since been on the Private Nursing Staff, was appointed Probationary Surgical Night Sister.

On May 26th, Nurse Worsley, Head Nurse in Addison Ward, left the Hospital on completion of her three years' training, and Probationer P. Wallis was appointed to succeed her as Head Nurse.

On May 28th, Nurse Ballance left the Hospital on completion of her three years' training, and Probationer E. M. Turner was appointed to succeed her as Head Nurse in Bright Ward.

On May 28th, Nurse M. Gray left the Hospital on completion of her three years' training, and Probationer Haward was appointed to succeed her as Head Nurse in Job Ward.

On May 30th, Nurse Foxon left the Hospital on completion of her three years' training, and Nurse Stone, Head Nurse in Victoria, was appointed to succeed her as Head Nurse in Esther Ward, Probationer Strappini being appointed Head Nurse in Victoria.

On May 30th, Probationer Sowter was appointed Head Nurse in Patience and Samaritan Wards.

On May 31st, Nurse Lucas left the Hospital on completion of her three years' training, and Probationer Du Boulay was appointed to succeed her as Head Nurse in Bright Ward.

On June 3rd, Nurse Shaw left the Hospital on completion of her three years' training, and Probationer Allen was appointed to succeed her as Head Nurse in Lazarus Ward.

On June 5th, Nurse Keays left the Hospital on completion of her three years' training, and Probationer F. Browne was appointed to succeed her as Head Nurse in the Out-patient Department.

On June 8th, Nurse Molesworth left the Hospital on completion of her three years' training, and Probationer New was appointed to succeed her as Head Nurse in Stephen Ward.

On June 13th, Nurse Mawson left the Hospital on completion of her three years' training, and Probationer Harris was appointed to succeed her as Head Nurse in Dorcas Ward.

On June 21st, Nurse E. Smith left the Hospital, having completed her three years' training on May 28th. Nurse V. Lowe was appointed to succeed her as Head Nurse in the Out-patient Department.

Miss Margaret Atkey, who completed her training in June, 1904, and has held the appointments of Second Home Sister, Sister in Charge of Addison Ward, and Night Sister, has been appointed Matron of the Newport and Monmouthshire Hospital.

On May 12th, an Extraordinary Meeting of the Council of the Guy's Hospital Past and Present Nurses' League was called to pass a vote of condolence with Her Majesty Queen Alexandra on the death of His Majesty King Edward VII.

The Countess of Bective presided, and moved the following resolution, which was passed in silence:—

"That the members of the Guy's Hospital Nurses' League humbly beg to offer to Her Majesty Queen Alexandra their sincere sympathy and condolence on the lamented death of His Majesty King Edward VII.

"They hope that Her Majesty may derive some consolation in her sorrow from the respectful assurance that the members of a profession in which Her Majesty takes so active an interest share her grief for the loss of one who himself did so much for the Hospital of which he was President and Patron."

The resolution, signed by the Matron, was forwarded to Buckingham Palace, and the following reply has been received:—

COPY.

Home Office,
Whitehall.
June 9th, 1910.

Madam,

I am directed by the Secretary of State to inform you that the message of condolence of the members of the Guy's Hospital Nurses' League, on the death of His late Majesty King Edward the Seventh, has been laid before Queen Alexandra, whose thanks I am to convey to you.

I am, Madam,
Your obedient Servant,
(Signed) EDWARD TROUP.

The Hon. Secretary,
Guy's Hospital Nurses' League.

PERIODICALS RECEIVED.—The Hospital, The Clinical Journal, St. Bartholomew's Hospital Journal, London School of Medicine for Women Gazette, London Hospital Gazette, International Journal of Surgery, The Polyclinic, South African Medical Journal, Nursing Times, V.C.L. Union Magazine, Indian Medical Gazette, Gazeta Medica de Costa Rica.

Jaundice due to Chronic Pancreatitis.

CLINICAL LECTURE BY Mr. ROWLANDS.

Gentlemen,—The object of this lecture is to draw your attention to the importance of remembering chronic pancreatitis as a cause of persistent jaundice. This condition, which is amenable to surgical treatment, has been very frequently mistaken for inoperable malignant disease, with the result that many valuable lives have been lost. Either no operation has been advised, or the abdomen having been opened the surgeon, on feeling the hard pancreas, has diagnosed carcinoma and has closed the abdomen without doing anything more. During the last two years I have operated upon three patients suffering from chronic pancreatitis with jaundice and great wasting. In all these the suspicion of malignant disease was very strong both before and during operation, but in spite of this the gall-bladder was joined to the small intestine in each case, and all the patients made a complete recovery from what appeared to be hopeless conditions. Brief accounts of the cases will be given and then some remarks will be made upon diagnosis and treatment.

Case 1.—C. M., æt. 35, a police constable, was admitted into Guy's Hospital, under Dr. Lauriston Shaw, on February 6th, 1908, for pain in the upper part of the abdomen on the right side and jaundice. For about two months the patient had suffered a good deal from indigestion and pain about the epigastrium and gall-bladder region. He often vomited soon after meals, and occasionally had diarrhœa. He soon became jaundiced. His stools became light-coloured and his urine very dark. Upon admission the jaundice was a little better, but the attacks of pain were very severe, only being relieved by morphia. The pain was above and a little to the right of the umbilicus and extended straight through to the back. The patient did not get pale, and was not sick in the attack. The upper part of the abdomen was tender and rigid, especially to the right of the middle line. The gall-bladder was feelable. By February 19th the jaundice was worse again, the attacks of pain were more severe, and the patient was wasting rapidly. Dr. Hertz advised exploration.

Operation.—When the abdomen was opened through the upper part of the right rectus, the gall-bladder was found to be enlarged. No stones could be felt in it or in any of the bile ducts, or at the common opening of the common bile and pancreatic ducts into the duodenum. The head of the pancreas was enlarged and very hard, and was thought to be carcinomatous. A small piece was removed for microscopical examination; this was later shown to be inflamed pancreas only. On carefully palpating the pancreas no stones could be felt. An anastomosis was made between the fundus of the gall-bladder and the jejunum about nine inches from the duodeno-jejunal flexure. The duodenum was too fixed to be conveniently used for the anastomosis, which was made by means of direct suturing with the aid of clamps. The opening was made as large as possible. Three layers of sutures were used. The abdomen was completely closed. The patient made an uninterrupted recovery. He never had another attack of pain. The jaundice soon disappeared, and he rapidly gained weight and left the hospital on March 13th. Since then he has been working uninterruptedly as a police constable. He came to see me in May, 1910, looking and feeling very well. He said that he had had no pain or indigestion since the operation. At the time of the operation the patient's wife was told that the disease was probably malignant, but, fortunately, this information was kept from the patient, who knew nothing of the suspicion until he was quite well.

Case 2.—A. D., æt. 34, was admitted into Guy's Hospital, under Dr. Lauriston Shaw, on March 3rd, 1908. About eighteen months ago the patient was in an infirmary. She was very ill, but no definite diagnosis was made. Typhoid fever and influenza were suggested. There was a good deal of fever, and a purpuric rash appeared all over the body. She had a great deal of abdominal pain. Seven weeks before admission into Guy's the patient had a feverish attack lasting three weeks. She had two rigors and pain in her limbs. A diagnosis of influenza was made. Soon afterwards she had a good deal of pain on the right side and she became jaundiced. The pain got gradually more severe and the jaundice got deeper and deeper. The patient wasted a great deal, and when she was admitted into "Clinical" she was very deeply jaundiced and thin. While in the hospital she had attacks of severe pain in the upper and right part of the abdomen. The gall-bladder was feelable. There was a great deal of tenderness and rigidity just above the umbilicus. A diagnosis was made of obstruction of the common bile duct, probably due to stone. The abdomen was opened through the upper part of the right rectus. The gall-bladder was distended. All the biliary apparatus was carefully

examined for stone, with a negative result. The head of the pancreas was considerably enlarged and hard. No stone could be felt about the pancreatic duct or the duodenal papilla. An anastomosis was made between the fundus of the gall-bladder and the jejunum. There was a good deal of oozing of blood during the operation. A tube was therefore placed in the right kidney pouch for drainage. The patient did very well for a few days, but about three weeks later, when I was laid up with pneumonia, Mr. Turner drained a subdiaphragmatic collection of sterile blood and serum. The patient then rapidly recovered and left the hospital well on May 10th.

CASE 3.—A dock labourer, æt. about 40, was admitted into Guy's Hospital under Sir Cooper Perry, on May 24th, 1909, for deep and persistent jaundice of about five weeks' duration. He had served in the Army for thirteen years, and thinks that he had syphilis in India in 1896, and a slight attack of dysentery during the South African War. He had vomited nearly every morning for two years, but had otherwise been in good health until April 20th, when he vomited a pint of sour green liquid. He felt ill on the following day and gradually became jaundiced. He consulted a doctor on April 23rd, and was treated with mercury and iodide of potassium. The motions were clay-coloured and the urine was very dark.

Examination.—Upon admission he was jaundiced. The liver was enlarged. The patient had no pain, and said that he had had none. Gradually the jaundice became deeper until it was greenish-black, and the patient gradually lost flesh. He suffered a good deal from itching of the skin. The gall-bladder could be felt, and there were also a vague swelling and tenderness just above the umbilicus in the middle line. The temperature was never raised above the normal. A diagnosis of growth or syphiloma of the pancreas was made, and an exploration was advised. On the 20th July the abdomen was opened and the biliary apparatus was examined in the usual way, but no stone was discovered. The gall-bladder was enlarged and distended. The head of the pancreas was enlarged, hard, and fixed. There was another distinct and hard enlargement near the tail of the pancreas. These were thought to be malignant. The liver was also considerably enlarged, but no growth could be seen or felt in it. Cholecyst-jejunostomy was performed. The limbs of the jejunal loop sagged, thus tending to produce a kink. They were each held up by means of a suture passed through the capsule of the liver. The abdomen was completely closed. To everybody's surprise the patient made a rapid and complete recovery. He is now in perfect health and doing heavy work.

Chronic pancreatitis was first described by Baillie as long ago as 1799, but little attention was paid to it until the classical work of Fitz[1] appeared in 1889. Our knowledge of the surgical aspects of the condition is chiefly due to Mikuliez[2] and Mayo Robson[3]. Chronic pancreatitis may be due to a variety of causes, prominent among which is ascending infection from the duodenum. It may also follow obstruction of the pancreatic duct or biliary papilla by calculi. It is particularly important to remember that pancreatitis nearly always follows the long-continued impaction of a gall-stone in the ampulla of Vater. In such cases pancreatitis is a serious complication, which we should always try to avoid by the early removal of the stone.

(1.) *Diagnosis.*—It has been recently asserted that catarrhal jaundice is commonly due to a form of acute pancreatitis of comparatively mild degree, as shown by local tenderness over the pancreas and a positive Cammidge's reaction. But in this lecture I am only concerned with *chronic jaundice* lasting several weeks.

(2.) *History.*—The history of previous attacks of jaundice associated with colic, or of colic alone, is in favour of gall-stones. A beginning with vague pains in the epigastrium, associated with fever and the gradual appearance of jaundice, is in favour of pancreatitis.

(3.) *Pain.*—The impaction of a stone in the common bile duct is usually associated with attacks of severe colicky pain. The pain is especially bad at the moment of impaction. The patient is sick and pale, with a small feeble pulse, and shivering may occur. No relief is afforded except by morphia or the lapse of time. Typical biliary colic is much more sudden and severe than that associated with pancreatitis or malignant disease of the pancreas. It may pass away as suddenly as it came. It is felt deep in the right side above and to the right of the umbilicus, and it extends to the back and especially towards the right shoulder. The pain associated with pancreatic disease is less violent and is unaccompanied by shock. It is lower, and extends to the back lower down and more to the left than that of biliary colic. In some cases the impaction of a stone in the common

[1] Ann. of Surg., 1903, vol. xxxviii, p. 1.

[2] Ann. of Surg., 1903, vol. xxxviii, p. 1.

[3] Hunterian Lectures, *Lancet*, 1904, vol. 1, pp. 773, 845, 911.

bile duct is not associated with any pain. Nausea then takes its place.

(4.) *Tenderness.*—The local tenderness, due to impaction of a calculus, is usually higher and more to the right than that due to pancreatic disease.

(5.) *The jaundice due to stone* is more intermittent than that due to pancreatitis, and especially than that due to growth, which gets progressively deeper. The jaundice due to pancreatitis is rarely so deep as that due to growth, but when chronic pancreatitis has lasted a long time the jaundice may become very deep or even greenish black, as in one of my cases.

(6.) *Enlargement of the gall-bladder* is against gall-stones as a cause of jaundice, although there are exceptions to this rule like all others.

(7.) With growth or pancreatitis, *a vague swelling* about the umbilicus is sometimes felt, especially when the patient is under an anæsthetic.

(8.) *Severe anæmia and wasting* occur in pancreatitis and growth, but not until quite late in jaundice due to stone in the common bile duct. So severe are the blood changes, that many cases of chronic pancreatitis with but slight jaundice have been diagnosed as pernicious anæmia.

(9.) *Diarrhœa* with fatty and fœtid stools containing muscle fibres is commonly associated with pancreatitis and also with carcinoma of the head of the pancreas. A stone impacted at the common opening of the pancreatic and bile duct may give the same signs.

(10.) *Cammidge's reaction* is rather complicated for general use, but it should always be tried, for a positive reaction strongly points to inflammation as against growth of the pancreas. Dr. Chalmers Watson[4] after a laborious research has recently drawn fresh attention to the great value and limitations of this reaction. It may be positive when a gall-stone obstructs the pancreatic duct and causes secondary pancreatitis, but it must not be forgotten that the reaction may be positive in certain other conditions, notably advanced arterio-sclerosis, which is often associated with some fibrosis of the pancreas. It is important to try the reaction in every case for operations for malignant disease if the pancreas afford little or no relief. Sclecht's test for pancreatic disease is simple and is said to be reliable. A drop of liquid fæces is placed on a serum-plate and incubated at 55° C. for a few hours, when a depression in the serum appears if the fæces contain trypsin. If the test is negative it may be concluded that the pancreatic juice is prevented from reaching the intestines. Excess of fat interferes with the reaction and has to be moved with ether.

(11.) *Glycosuria* is rare in cancer of the pancreas, but common in late cases of chronic pancreatitis. Here the appearance of the sugar is not a contra-indication but a warning of the urgent need of operation.

(12.) *Exploration.*—It is important to remember that an exploration is often necessary to make the exact diagnosis of the cause of chronic jaundice. It carries with it very little risk, and it often prevents delay when time is most valuable.

Treatment.—The abdomen is opened through the upper part of the right rectus, the upper end of the incision being carried inward towards the middle line, if necessary. All bleeding points are carefully tied, because of the well-known risk of death from hæmorrhage which is associated with chronic jaundice. The gall-bladder and the bile ducts are examined for stone, special attention being paid to the head of the pancreas and to the biliary papilla. This preliminary and very careful palpation is of the utmost importance, because the discovery and the removal of a small stone from the biliary papilla is the best and most certain way of curing the patient. I published such a case (a patient of Dr. Fraser, of Romford) in the GUY'S GAZETTE last year. It is very difficult or impossible to feel a small stone impacted in the pancreatic duct, surrounded as it is by hard and thickened pancreas. When no stone is discovered, but only hard and enlarged pancreas, it is very difficult, and may be sometimes impossible, to decide between growth and pancreatitis. Owing to this uncertainty it is best to treat the condition as pancreatitis. In some cases mere palpation of the pancreas has been followed by recovery, which has been thought to be due to the separation of adhesions or the dislodgment of a calculus. There is no doubt that opening and draining the gall-bladder has a wonderful curative effect upon pancreatitis. Moreover, it may ease pain and delay the end in carcinoma of the pancreas. The gall-bladder may be drained either—

(*a.*) On to the surface.
(*b.*) Into the intestine.

(*a.*) *On to the surface.*—There is little doubt that draining the gall-bladder on to the skin is safer than making an anastomosis between it and the intestine, and this is especially true for those surgeons who are not frequently making

[4] The Lancet, vol. i., 1908, p. 232.

anastomoses. A biliary fistula is, however, an unpleasant thing. The bile irritates the skin, and, moreover, it is lost for digestive purposes. In most cases of pancreatitis, however, the biliary fistula closes after some weeks if the gall-bladder is not sewn to the skin but to the parietal peritoneum. The operation may have to be repeated if pancreatitis with jaundice recurs.

(*b.*) *Draining into the intestine.*—In the early days of gall-bladder surgery, cholecystenterostomy carried with it a very high mortality, especially in malignant disease of the pancreas; but the high death-rate was chiefly due to the technique of the operation, the button or bobbin being used. A thin and hard gall-bladder is ill-adapted for such mechanical supports, which too frequently led to sloughing. A suture operation with the aid of clamps, if carefully done, is not very dangerous. Care must be taken to make the opening large enough. The gall-bladder may be joined to the duodenum, the stomach, the jejunum, or the colon. The duodenum is the physiological ideal, but in these cases it is not always easy to bring it up sufficiently into the wound. Moreover, I believe that union is more certain when the jejunum is used. For these reasons I chose the jejunum in my three cases. It has been shown that the stomach can be used successfully, but it is too thick for choice. The hepatic flexure of the colon is near and convenient enough, but it is far better to turn the bile into the small intestine. In a very few cases ascending suppurative cholangitis has followed a cholecystenterostomy, and for this reason some surgeons have done an entero-anastomosis at the same time. This is unadvisable as a routine measure, because it adds to the severity of the operation without conferring certain immunity from ascending infection of the bile ducts, which is, after all, a rare complication.

Papers by Guy's Men.

W. H. Bowen, M.S. Lond., F.R.C.S. Eng., and H. B. Carlyll, M.B., B.C.: A Case of Sarcoma of the Petrous Bone (Illustrated).—*British Medical Journal*, June 25th, 1910.

Claud F. Fothergill, M.B., B.C. Camb.: Case of Impacted Gall Stones in Cystic Duct. Operation; Recovery.—*British Medical Journal*, July 2nd,, 1910.

Herbert French, M.D. Oxon., F.R.C.P. Lond.: A Case of Exostosis of the Os Calcis (Illustrated).—*The Practitioner*, July, 1910.

At Kingswood Warren.

ON Tuesday and Wednesday of last week Mr. and Mrs. Cosmo Bonsor gave a garden party in the beautiful grounds of Kingswood Warren to the Nurses and Sisters, and the Staff of the Hospital. The guests went down by special train from London Bridge, accompanied by Mr. Bonsor, who met them on the platform.

On the Tuesday we were favoured by very good weather, on the whole. There was a little rain during luncheon, but the weather afterwards cleared up, and during the rest of the afternoon was all that could be wished for. After luncheon the party scattered over the grounds to enjoy the various amusements which were provided. A tent wherein "fortunes" were told by palmistry proved a great attraction, and quite a considerable queue seemed to be waiting outside it the greater part of the afternoon. We heard no complaints about the fortunes which were told, so we suppose they must have been to everyone's satisfaction. The Aunt Sallys were another great attraction, and they were aimed at so often that they were quite frequently hit. Close by was a game called "Stepping Stones," which required considerable balance and nerve, but several nurses, we noticed, won prizes at it. By rides on a switchback some of the guests kindly provided a source of amusement for the others. There were also skittles and see-saws, and other games we do not know the names of. Some enthusiasts even played tennis in high heels. On the see-saws, we regret to say, an unfortunate accident occurred; one of the nurses had the misfortune to sustain a fracture of the tibia and fibula. She was taken up to the hospital by motor car, and admitted into Martha Ward.

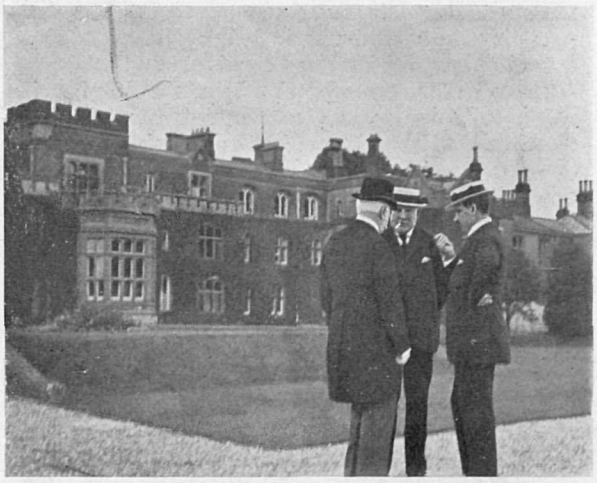
A very popular amusement was rides on a motor through the beautiful country around Kingswood Warren. For those who were unable to get a place in the car there was the alternative of a governess cart drawn by a very good-tempered donkey, who could be encouraged, by whipping and suitable oaths, to do a fairly respectable pace. The patient little creature received no formal vote of thanks, so we should like to record here our appreciation of his good qualities. There was also a pony, who is said to have thrown his fair rider, but we hope not violently.

When the time came for us to leave for the special train back to town, everyone felt genuinely sorry that the day, like all good things, must come to an end. Such a day, in the heart of beautiful Surrey, is an experience all too rare to most of us, who are tied to the squalid Borough that we love so much. In proportion to its rarity, it was appreciated, and we could all heartily echo the words of Dr. Eyre, who, on behalf of the company, thanked Mr. and Mrs. Bonsor for their great kindness as our hosts. They have the great gift of making everyone feel at home; moreover, at a very beautiful and delightful home.

The Start.

Lunch in the Marquee.

Arriving at Kingswood.



Mr. Gordon, Mr Bonsor, and Lord Goschen.

In the Grounds.

The See-Saws.

At Kingswood Warren.

(Photographs by Miss Smith.)

Those Nurses and Residents who went down on Wednesday were not favoured by such auspicious weather, we understand, but they managed to spend a thoroughly enjoyable day at indoor amusements.

The photographs illustrating the garden party, which will be found as an inset, were taken by Miss Smith, who was busy "snapping" incidents all the afternoon, and has very kindly allowed the GAZETTE to reproduce some interesting pictures.

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

Museum Collection of Ancient Instruments.

DEAR SIR,—I have to acknowledge the receipt from Dr. B. Jones, Lytham, Lancs., and his relative Dr. J. Jones, of Leigh, of the following additions:—

(*a.*) Early 19th Century catlin.

(*b.*) Case of instruments for scarification and cauterizing the cervix uteri.

(*c.*) Air pump form of breast pump.

These instruments are interesting, for a generation ago, as Dr. B. Jones says in his letter to me, they represent all that we could do for inflammatory troubles of the uterus. I recently placed in the Museum a complete case of surgical instruments such as were issued to surgeons on passenger ships. The date is 1849. It is an interesting point to notice that, with the exception of the gum elastic catheter, the instruments are the same as might have been used by Ambrose Paré in the 16th Century. Till the acceptance of the teachings of Lister, surgery remained practically unaltered.

Anæsthesia alone did little to add to the bounds of surgery, but combined with Listerism it has placed the Art where it is. It is somewhere from this standpoint that I am trying to get together the working tools of the past. These are fast disappearing into the limbo of extinct conditions, and if not soon gathered will never appear in our Gordon Museum.—Yours truly,

1, Porchester Houses,
Porchester Square, W.
June 22nd, 1910.

F. WILLIAM COCK.

Boy Scouts.

DEAR SIR,—I shall be most sincerely obliged if you will allow me, through the agency of your columns, to make an appeal on behalf of a cause which I have deeply at heart.

Last week I received a note from Mr. W. E. Cook, the Superintendent of the Colliers' Rents Mission in Long Lane, Boro', soliciting my help on behalf of a troop of Boy Scouts, which he has recently formed in connection with that institution.

Since then I have had an interview with him, and ascertained that he is particularly anxious to find some assistant who can undertake to give the boys a little instruction in first-aid and ambulance work of an elementary kind; while he will also be glad of help in other directions, as for example: gymnastics, etc. Having already a small troop of Boy Scouts of my own, as well as Territorial and other calls upon my time, I I have been obliged to tell him, most reluctantly, that it is not possible for me to undertake any further duties of this kind.

There must be, however, a number of men in Guy's Hospital who will see in the Boy Scout movement, as I do, a ready means whereby any man may take some part, however small, in the great work of helping the future manhood of England to become a little better prepared for the imminent dangers to which our country must inevitably be exposed in the not far distant future.

If any Guy's man who shares my views on this subject, and wishes to support his views with something more substantial, will be good enough to communicate with me, I shall be only too pleased to put him in the way of making himself useful. I may conclude by saying that, as I have recently received a similar appeal for help from a friend in Kensington, and might be glad of a little assistance with my own Scouts from time to time, I hope that no man who is willing to do something will refrain from coming forward on the ground that his help is not required.

Thanking you in anticipation for your kindness in helping me to make this appeal public, I remain, yours very truly,

July 5th, 1910. RICHARD G. ORAM.

Guy's Hospital Swimming Club.

DEAR SIR,—Would you allow us, on behalf of the above Club, to thank all those who were kind enough to assist us in our annual entertainment both by presenting us with prizes and by acting as officials.—Yours truly.

W. T. CLARKE, } *Hon.*
H. N. ECCLES, } *Secs.*

Papers by Guy's Men.

W. H. Pilcher, J.P., L.D.S. Eng.: Ethics in Conduct of Practice.—*British Dental Journal*, 1st July, 1910.

Charles E. Salter, M.D., B.S. Lond., F.R.C.S. Eng.: Gall Stones; Acute Pancreatitis; Recovery.—*British Medical Journal*, 2nd July, 1910.

E. I. Spriggs, M.D. Lond., F.R.C.P. Lond.: The Treatment of Indigestion.—*The Clinical Journal*, 22nd June, 1910.

R. M. Wormald, L.D.S. Eng.: Malocclusion and its Treatment with Fixed Appliances.—*British Dental Journal*, 16th June, 1910.

Old English Ballad.

The Karl hath taken twenty frogs
And eke another twain.—
"By my stromūhr, I swear to break
The rede of Haidenhain!

"Come hider, come hider, my little lab-boy,
Come hider unto me;
And for the gear I thee shall tell,
Go seek it speedilly.

"A blackened scroll on a turning wheel,
And a writing point also:
A coilèd wire with spark of fire,
The wherefore none may know.

"And on the board aboon thy head
Botèls in line there be.
The very first one upon the board,
Now bring it not to me.

"And the very next one thy eye shall mark
Now leave it where it stand.
But the third botèl upon the board
Bring hider in thy hand."

The boy hath found the blackened scroll,
The writing point also,
The coilèd wire with spark of fire,
The wherefore none may know.

The Karl doth set his gear in place,
The blackened scroll winds round.
He Spencer-Wells each frog and cuts
Till the dorsal sac be found.

He hath fixed a sound to the dorsal sac,
To know the force within,
And another to the mighty vein
I' the neck beneath the skin.

The upswell here and the upswell there
The writing points let tell.
"If the reading here and the reading there
Are alike: then all is well."

The pointer here, the pointer there,
He followeth with his eyne.
When he was aware of a man stood there.—
"Fore God, 'tis Haidenhain!"

With scornful air and mocking sneer
Karl Ludwig bowes him low.—
"In my humble lab there is no crab
That makes the lymph to flow!

"I am a plain and simple man,
And swink with homely gear.
But for a testing of thy rede
On the blackened scroll: Look here.

"The reading here from the dorsal sac,
And there from the mighty vein."
Quod Ludwig, "An they tally well,
The fight is al-to-gain."

"An they tally well," quod Haidenhain,
Thy rede hath won the day:
And the law of the bits with holes between
Shews forth the body's way.

"But if," quod he, "they tally not,
And the upswells disagree,
Why then the sight is a living deed,
And the battle is to me."

"Agreed, agreed," Karl Ludwig cried,
And near the wheel they stand,
With shoulders bent and all besprent
The writing points they scanned.

When the turning wheel had wended twice
The Karl was full of glee,
When the turning wheel ten times had turned
A tear stood in his ee.

"Now by my sooth," cried Haidenhain,
"The gain is all to me,
For the upswell here and the upswell there
In no wise do agree."

Karl Ludwig was a troubled man,
But of guile he has no fail,
He bethinketh him of wondrous saws
Of Bainbridge and of Dale.

"Oh an endless tale of bits," he cried,
In a hollow tube mounts high,
Of their upswell doth Starling tell,
Who may not speak a lie."

"Go tell that saw," quod Haidenhain,
"To the soldiers on the sea.
The reading here with the reading there
In no wise doth agree."

"'Tis the call of the salts that may not pass
Thro' the endothelial cell,
They cry for water from the blood,
Like Dives down in Hell,
And thus the force from the dorsal sac
Doth mightily upswell."

The talk hath crossed from each to each,
And neither yields his ground,
For every saw of Haidenhain
Another hath Ludwig found.

And still they fight, by day by night,
And none the sooth may know;
What mighty force with hidden source
Doth make the lymph to flow.

S.

Rigors.

A RIGOR is a definite clinical phenomenon, occurring in a variety of conditions.

It is characterised chiefly by three things:—

1. Sudden, temporary pyrexia.
2. Muscular tremors—rapid, slight, alternate contractions and relaxations of antagonistic muscles.
3. Cutaneous vaso-constriction.

One can compose a long list of diseases in which rigors may occur. But, perhaps, a clearer view of this symptom can be obtained by considering the commoner instances.

Quite a large proportion of rigors take place during pyogenic invasions of the body, especially when the invasion takes place by certain routes. Patience and Samaritan wards always have plenty of septic cases, but rigors are not frequent. It is sometimes said that rigors mean suppuration; but this is an imperfect statement. Sepsis is particularly prone to give rise to rigors when it is present in certain parts of the body. These situations are:—

1. The neighbourhood of the middle ear;
2. The urinary tract, especially in the male;
3. The cancellous tissue of long bones;
4. The cranial bones;
5. The uterus and its surroundings.

All these regions share one anatomical feature: each exhibits large and, for the most part, patent venous spaces. Thus, the middle ear lies near to the lateral sinus, the large size and uncollapsible character of which are well known. The urethra lies enveloped amongst the wide open spaces of the corpus spongiosum, whilst between the capsule of the prostate and its fibrous sheath of pelvic fascia exists a considerable plexus of veins. The cancellous tissue of long bones is said to contain unusually patent veins. [With this condition of veins in cancellous bone there may be associated, not only the liability to venous infection, but also the malignancy of bone sarcomata, the occasional occurrence of miliary tuberculosis after the excisions of tuberculous joints, and the rare event of fat embolism in fractures.] The cranial bones contain the large diplöic spaces, and beside the uterus lie vast plexuses of veins.

In each instance the risk of venous infection is obvious, and the relative frequency of pyæmia well known. When infection in the tissues extends to a vein, pressure of inflammatory products tends to occlude the lumen, and local irritation of the intima results in thrombosis, thus protecting the venous system. But if the vein does not collapse, and septic changes occur in the clot, there may be a sudden entry of toxins and disintegrating clot into the venous circulation. This pathological event is manifested clinically by a rigor. The infected portions of clot may lead to pyæmia and septicæmia. The association of rigors with pyæmia is well known. In pyæmia, the organisms embedded in septic clot are conveyed, at intervals, from the primary site of infection to block the first set of capillaries—those of the lung or the liver as the case may be—and from each septic embolus an abscess may be derived. In the more serious condition of septicæmia the organisms are actually living and even multiplying in the blood stream. Pyæmia often leads to septicæmia, and, conversely, septicæmia often leads to remote abscess formation, the bacteria circulating in the blood obtain a footing in some other tissue, such as the kidneys, the serous cavities, or any tissue of depressed resistance, and there more or less reaction will lead to suppuration or inflammation.

A single rigor, that is a single breaking up of clot, does not always result in pyæmia, though repeated rigors of septic origin are commonly followed by distant abscess formation. In septic urinary states the single "catheter rigor" may not lead to recognisable blood dissemination. This rigor, curiously enough, often occurs, not immediately after the passage of an instrument along the urethra, but on the next occasion that the patient micturates. The passage of urine, perhaps, finally dislodges the septic clot in the corpus spongiosum which may have been formed by the passage of an instrument along the septic urethra. The urethral rigor has been fancifully compared to the initial shiver which sometimes accompanies the normal act of micturition. But this is probably wrong. Again, most charities are familiar with the violent rigor which may follow the "clearing out" of a septic uterus. Here, sometimes, obvious blood infection does not ensue. It is most doubtful, however, whether a rigor ever occurs in these cases in the absence of sepsis.

These facts have an important bearing upon surgical treatment. For some years in the case of the ear, and more recently in the case of the uterus, and in osteomyelitis of the long bones, ligature of the vein draining the affected area has been practised in cases of threatening blood infection. If the rigor actually corresponds in time to the dissemination of septic material in

the blood stream, the repeated rigors seen in pyæmia mean repeated infections of the blood, and could be prevented by ligature of the efferent vein. If these assumptions be accurate, ligature of the efferent vein should be practised wherever possible, and with some degree of hopefulness, especially if no more than one rigor has occurred.

Cases of systemic infection have so far been touched upon. The association of rigors with blood infection is also seen in cases of portal and, more rarely, in cases of arterial pyæmia. Repeated rigors in a case of appendicitis can only mean one thing, namely, portal pyæmia. In malignant endocarditis portions of infected clot may break away.

An instance where the presence of rigors may have some influence upon treatment is seen, occasionally, in appendicitis. Here the occurrence of rigors demands immediate and radical treatment; adhesions should be broken down and the appendix removed, even at the risk of spreading infection through the peritoneal cavity.

Apart from septic conditions, rigors occur, perhaps, most often in malaria and at the onset of lobar pneumonia. In the former, at least, an analogous state of affairs to the breaking up of septic clot may be traced. For each attack of ague, which is a typical rigor, corresponds to the breaking up of the red corpuscles with the escape of myriads of hæmamœba spores.

What is the exact mechanism of a rigor? The tremors cannot be due to the pyrexia, nor even to the suddenness of the pyrexia. In cases of heat stroke, the temperature will rise to over 110°F. in the space of a few hours, and this sudden rise will be unaccompanied by rigors. Moreover, a rigor may set in when the temperature is already high. Embolism by small particles of clot cannot be the cause of the symptoms, for they appear both in systemic pyæmia, where the lungs are the seat of embolism, and in portal pyæmia, where the liver is the seat of embolism. The phenomenon is most probably due to the sudden saturation of the body by toxins and the products of decomposition of the clot. Whether these poisons act upon the muscle directly or upon the nerve centres is uncertain, but is capable of clinical elucidation. All that is wanted is pyæmia occurring in a patient with a recent nerve paralysis. For instance, in a patient with middle ear suppuration, recent facial paralysis, and lateral sinus thrombosis, is it not possible to determine whether the tremor, during a rigor, is confined to the unparalysed side of the face? The shivering can hardly be the result of the vaso-constriction, since it cannot be abolished by the external application of warmth. The view that the profound toxæmia is responsible for the rigor accords well with the sensation of chill which ushers in so many acute infections.

K. H. D.

Appointments.

The following appointments and re-appointments have been made by the Treasurer upon the recommendation of a Staff meeting:—

Assistant Dental Surgeons.—Messrs. Parfitt and Payne.

Anæsthetists to the Hospital.—Messrs. Page, Shipway, Cameron, Davies-Colley and Thompson.

Anæsthetist to Bright Ward.—Dr. Cameron.

Dental Anæsthetists.—Messrs. Lancaster, Ogle, Shipway, Davies-Colley and Layton.

Medical Registrars.—Messrs. Cameron and Rippmann.

Obstetric Assistant.—Mr. R. Davies-Colley.

Surgical Registrar.—Mr. Townrow.

Ophthalmic Assistants.—Messrs. Anderson and Zorab.

Resident Surgical Officer.—Mr. Trethowan.

Demonstrator of Pharmacology.—Mr. Ryffel.

Clinical Analyst to the Wards.—Mr. Ryffel.

Assistant Bacteriologists.—Messrs. Catto and Browning.

Demonstrators of Anatomy.—Messrs. Thompson, Hughes and Layton.

Demonstrators of Physiology.—Messrs. Kennaway and Ryffel.

Demonstrator of Chemistry and Organic Chemistry.—Mr. Ball.

Demonstrator of Chemistry and Physics.—Mr. Merriman.

DENTAL SCHOOL.

Demonstrators of Practical Dentistry with Charge of Revision Classes.—Messrs. Dowsett and Pearce.

Demonstrators of Practical Dentistry with Charge of Probationary Classes.—Messrs. Aubrey and Malleson.

Demonstrator of Operative Dentistry.—Mr. Chapman.

Demonstrators of Prosthetic Dentistry.—Messrs. Charles and Tomes.

Demonstrators of Dental Microscopy.—Messrs. Dowsett and Kennaway.

Curator of the Dental Museum.—Mr. Dowsett.

From the Gazette's Special Pathologist.

W. L. W. M., HUDDERSFIELD.—This piece of tongue in infiltrated by a malignant growth, having the characters of a squamous epithelioma. It is composed of branching epithelial ingrowths, with much cell-nest formation and keratinisation.

PATHOLOGIST.

Sport.

Cricket.

GUY'S v. HAMPSTEAD.

Played at Hampstead on June 22nd, and resulted in a draw. Hampstead won the toss, and compiled 240. Kahlenberg took six wickets for 99 runs. Guy's made 197 for seven wickets, the light at the end being very bad,

HAMPSTEAD.

Donaldson, b Kahlenberg	11
Howell, b Kahlenberg	6
Susskind, c Curnow, b Kahlenberg	80
Everitt, c Birks, b Harkness	10
Hale, b Kahlenberg	4
Maclure, c Birks, b Kahlenberg	18
Bisgood, c & b Montgomery	30
Dumbleton, not out	48
Beaton, c Kennedy, b Kahlenberg	0
Trimen, c Hunôt, b Digby	20
Marsden, c Birks, b Digby	7
Extras	6
Total	240

GUY'S.

M. M. Munden, b Everitt	11
A. H. Harkness, c Howell, b Dumbleton	2
A. H. Birks, b Hale	17
R. Montgomery, lbw, b Everitt	42
W. E. S. Digby, c Maclure, b Dumbleton	31
R. M. Veale, not out	29
F. C. Hunôt, b Everitt	1
R. S. Kennedy, b Everitt	4
A. F. Rook, not out	13
Extras	47
Total (7 wickets)	197

F. Kahlenberg and R. Curnow did not bat.

GUY'S v. M.C.C

Played at Honor Oak Park on June 28th. For Guy's H. C. Rook, A. F. Rook, and Veale batted well.

GUY'S.

M. M. Munden, lbw, b Geeson	6
R. Montgomery, c Curnow, b Reeves	0
R. M. Veale, b Geeson	30
H. C. Rook, b Geeson	64
B. F. Sampson, c & b Johnston	2
A. F. Rook, c Storer, b Johnston	34
W. Harris, c Reeves, b Johnston	8
A. H. Harkness, st Storer, b Johnston	5
R. S. Kennedy, st Storer, b Johnston	10
R. Curnow, not out	6
J. E. Rhys Evans, b Johnston	0
Extras	6
Total	171

M.C.C.

R. Kenward, c A. F. Rook, b Sampson	55
Major Lowis, lbw, b Harris	7
Capt. W. W. Jelf, b Curnow	2
T. G. Turner, b Harris	61
A. S. Johnston, c Harkness, b Curnow	8
F. E. Lander, c Harris, b Curnow	6
Reeves, b A. F. Rook	37
R. Y. Hedderwick, b Harris	7
Geeson, not out	7
G. C. Ives, b Harris	0
Storer, b Montgomery	4
Extras	27
Total	221

GUY'S v. LONDON.

INTER-HOSPITAL CUP TIE.—Semi-Final Round.

Played at Chiswick on Wednesday, June 29th, resulting in a win for Guy's by 150 runs. Guy's went in first on a slow wicket, and quickly lost four wickets for 23 runs. Birks and Digby then got going, the former not leaving until the score was 210. His century included fourteen "4's." Kahlenberg again bowled well, and secured four wickets for 29 runs. The Guy's fielding was exceptionally smart, many extremely good catches being held.

GUY'S.

M. M. Munden, b Clarke	1
R. Montgomery, c Adams, b Jones	6
A. H. Birks, c Herman, b Owens	118
R. M. Neale, b Clarke	7
H. C. Rook, c Dew, b Clarke	0
W. E. S. Digby, hit wkt., b Herman	29
A. F. Rook, c Powell, b Owens	39
F. C. Hunôt, c Dew, b Owens	24
R. S. Kennedy, c Jobson, b Clarke	1
A. C. Hancock, run out	23
F. Kahlenberg, not out	7
Extras	5
Total	260

LONDON.

F. A Powell, c Hancock, b Digby	0
A. A. Adams, c Birks, b Hunôt	11
A. Maitland Jones, c A. F. Rook, b Digby	7
N. L. Clarks, not out	33
A. E. Herman, c Munden, b Kahlenberg	21
J. W. Dew, c Montgomery, b Kahlenberg	1
J. S. Dobson, b Hancock	3
J. H. Owens, b Kahlenberg	8
L. C. Smith, c Digby, b Montgomery	4
O. de B. Marsh, c H. C. Rook, b Montgomery	5
J. C. Ellis, b Kahlenberg	3
Extras	14
Total	110

Annual Swimming Entertainment.

The Annual Entertainment of the Guy's Hospital Swimming Club was held at the Southwark Baths on Wednesday, June 29th. A large number of spectators were present, amongst whom were Sir Alfred and Lady Fripp, Dr. Newton Pitt and family, Mr. and Mrs. A. Ormond, Dr. and Mrs. J. Eyre, Mr. and Mrs. F. J Steward, Mr. and Mrs. Rowlands, Mr. and Mrs. Turner, Mr. and Mrs. Davies-Colley, Dr. and Mrs. Cameron, Mr. and Mrs. Hughes, Mr. and Mrs. Layton, and Messrs. C. H. Fagge, J. Lewin Payne, C. H. Rippmann, A. Allport, W. Anderson, P. Jackson, and Rev. A. Dunn.

The first event to be decided was the Sixty-six Yards Scratch Race (prize presented by Lady Fripp), which was productive of an exciting struggle between J. York Moore and H. H. Glover. So close was the finish, that, until the judge's decision in favour of York Moore, considerable doubt existed as to who had actually won. The winner's time was 44⅕ sec.

The Long Plunge (prize presented by J. Eyre, Esq.) went to J. Pryce Davies, with an excellent plunge of 52ft. 6in., J. H. Rhodes being second.

The Sixty-six Yards Handicap (prize presented by Mrs. F. J. Steward) resulted in a win for F. Tooth (13 secs. start), J. H. Rhodes (4 secs. start) being second. The winner's time was 52 secs.

The Nurses' Race, which was a two lengths handicap for a prize presented by the GUY'S HOSPITAL GAZETTE, was quite a feature of the evening's entertainment. We congratulate the winner, Nurse Tilleard (25 secs. start), and Nurse May (scratch), and Nurse Bairdshaw (8 secs. start), who were second and third respectively, on their plucky swimming. Eight nurses swam in this race, which we hope may keep a permanent and popular place in the annual sports programme.

Mr. Melville Clark kindly judged the Neat Diving (prize presented by P. S. Price, Esq.), which consisted of a dive from three heights, and one voluntary dive, and awarded the event to E. G. Schlesinger, C. E. Reckitt being second.

The Quarter Mile Handicap (prize presented by J. Lewin Payne, Esq.) showed some excellent swimming, M. Pern, from scratch, being beaten by some three yards. Result, G. W. Holloway (30 secs.) first, M. Pern (scratch) second. Winner's time, 7 mins. 36 secs.

The Cork Competition, in which each competitor endeavoured to pick up as many corks as possible with his mouth and place them in a hat, caused much merriment. M. Pern ultimately won with 14 corks, F. B. Stradling being second with 9 corks.

Following this came a Display of Diving by four members of the Amateur Diving Association, Messrs. Melville Clark, L. Hughes, H. J. Grimwade, and H. Eastes. The spectators' appreciation of this skilful and entertaining performance was shown in the loud applause which greeted each dive, while Sir Alfred Fripp expressed, on behalf of the club, its gratitude to these gentlemen for so kindly giving their services for the last four years in succession.

In the Duck and Drake Contest, W. T. Clarke, as duck, was speedily captured by J. Smythe.

The Obstacle Race (prize presented by C. H. Fagge, Esq.) was, as usual, a popular event, the competitors' efforts to surmount the suspended pole causing much merriment. Winner, J. York Moore; second, M. Pern.

The Full Clothes Race (prize presented by W. M. Mollison, Esq.) brought four entrants, W. T. Clarke, in a charming "Chantecler" costume, being just beaten by H. H. Glover, in a well-fitting suit of "whites."

A Polo Match between Guy's Hospital and Mr. H. N. Eccles' team followed. The Guy's team, which is a very strong one, and which was almost at full strength, displayed a superiority over their opponents greater than the result of three goals to two would indicate. All played a hard game, and, considering their previous exertions, a fast one, H. H. Glover's shooting being particularly praiseworthy. Teams:—

GUY'S.—J. Smythe, H. G. Rice, W. T. Clarke, F. B. Stradling, M. Pern, J. York Moore, and H. H. Glover.

H. N. ECCLES.—H. N. Eccles, Rhodes, Martin, Lendow, Holloway, Littlewood, and T. B. Layton.

The prize distribution by Lady Fripp terminated an enjoyable evening, for the success of which the secretaries, Messrs. W. T. Clarke and H. N. Eccles, deserve every praise. After cheers had been given for Lady Fripp, the club's popular president, Sir Alfred Fripp, expressed the satisfaction which the Committee felt at the success of the entertainment, and thanked on its behalf all those who had given such valuable help.

University of London Swimming Sports.

These sports were held for the first time on June 27th at the Lambeth Bath. Despite a rather poor attendance of spectators, an enjoyable evening was passed. Amongst the competitors, Guy's were well to the fore, J. York Moore winning the 100 yards in 1 min. 10⅕ sec., and J. Pryce Davies the long plunge with 52ft. 10½in., while both the obstacle race and the candle race went to A. N. Moberly. In the team race, Guy's were unlucky in losing to the London, but some of the Guy's team appeared obviously tired from their previous exertions. A polo match, Guy's v. Mr. Lendow's team, resulted in a draw of 2 goals each, after which Sir Alfred Keogh distributed the prizes. It is to be hoped that this meeting may become a permanent one, and that next year, when it is better known, the attendance may be a larger one.

Swimming.

GUY'S v. ST. THOMAS'S.

FIRST ROUND OF THE INTER-HOSPITAL SWIMMING AND WATER POLO CUP TIE.—TEAM RACE, FOUR A SIDE.

This resulted in an easy win for Guy's by 40 yards.

Team—Rhodes, Pern, Glover and York Moore. Time, 2 min. 59 sec.

Guy's had a walk-over in the water-polo, St. Thomas's being unable to raise a team.

GUY'S v. LONDON.

SEMI-FINAL.

Guy's were unfortunate in losing the team race by a touch, but proved successful in the water-polo, winning easily by 8 goals to nil.

Swimming team—Pern, Rhodes, Glover and York Moore.

Water-polo team—Smyth, Rice, Clarke, Pern, Glover, York Moore and Moberly.

GUY'S v. FOREST HILL.

In this friendly match Guy's won easily by 14 goals to 1.

Guy's Hospital Rifle Association.

The second and third shoots for the Hermitage Cup took place on Wednesdays, June 15th and 22nd. Result:—

SECOND SHOOT.		THIRD SHOOT.	
H. Platts	96	H. Platts	99
H. Hogben	94	H. Hogben	90
E. O. Yerbury ...	90	E. O. Yerbury ...	90
G. A. Blake	88	G. A. Blake	89
L. D. Wright	76	L. D. Wright	78
W. Robinson	45	J. E. Rhys Evans ...	76
	489		522

Others scores are not yet available.

The Annual Prize Meeting took place on Wednesday, June 22nd, at Bisley; the wind was rather tricky, and under the circumstances the shooting was good.

We have to thank the following gentlemen for contributions to the prize fund: Dr. Beddard, M. S. Pembrey, Esq., Messrs. Ash & Co., H. H. G. Grattan & Son, and the Holborn Surgical Instrument Company.

1. NEWTON PITT CHALLENGE CUP.—E. O. Yerbury, 90, Prize, The Cup. (H. Platts did not enter for this.)

2. HANDICAP COMPETITION.—H. Platts, 99, 1st prize, 17s.; H. Hogben, 90 + 4, 2nd prize, 12s.; G. A. Blake, 89 + 4, 3rd prize, 6s. 6d.; L. D. Wright, 78, 4th prize, 5s.; J. E. Rhys Evans, 76, 5th prize, 5s.

3. 600 YARDS COMPETITION.—H. Platts, 43, 1st prize, 17s.; H. Hogben, 42, 2nd prize, 12s.; E. O. Yerbury, 36, 3rd prize, 6s. 6d.

900 YARDS COMPETITION.—H. Platts, 31, barred for winning 2 and 3; E. O. Yerbury, 24, 1st prize, 17s.; G. A. Blake, 16, 2nd prize, 12s.

5. AGGREGATE COMPETITION.—H. Platts, 173, 1st prize, presented by Messrs. Down Bros.; G. A. Blake, 151, 2nd prize, Carvers presented by H. J. Grattan; E. O. Yerbury, 150, 3rd prize, presented by Holborn Surgical Instrument Company.

The shoot for the United Hospitals Challenge Cup, presented by the National Rifle Association, took place at Bisley on Wednesday, July 6th. Open to one team of six from each Metropolitan Hospital. Ten shots per man at 600 yards.

The conditions were not ideal for shooting; the light was bad, and a strong wind from the butts worried the competitors considerably. Scores:—

GUY'S.	
H. Platts	48
E. O. Yerbury	40
H. Hogben	40
J. E. Rhys Evans	39
L. D. Wright	38
S. A. Blake	35
	240

St. Mary's, 230; Bart's., 216; Thomas's, 176.

Guy's therefore won the Cup by ten points.

E. O. YERBURY, Hon. Sec.

Lawn Tennis.

INTER-HOSPITAL CUP TIES.

These matches took place at Chiswick Park on June 27th and 28th. In the semi-final St. Thomas's beat St. Barts.' by nine matches to three; and Guy's beat London by ten matches to five, 21 sets to 11, and 154 games to 131. The final between Guy's and St. Thomas's was played in windy weather, and resulted in a well-earned victory for us by nine matches to six, 20 sets to 14, 190 games to 163, after a very close fight.

This victory for us is most encouraging, considering that we unfortunately lost H. Sharpe (Captain) at the commencement of the season, and H. Chapple at the last minute. The latter's place was most ably filled by R. H. Lucas, who is to be congratulated on showing such consistent form after having captained the 2nd VI. into the Final of the Junior Cup on the three preceding days. Results:—

GUY'S v. LONDON.

SEMI-FINAL.

G. C. Covell lost to L. Powell, 0–6, 1–6; A. S. Roe beat S. G. Luker, 6–4, 6–2; R. Curle beat R. T. Vernon, 6–4, 6–2; H. W. Barber lost to F. T. Willans, 3–6, 3–6; R. H. Lucas beat G. C. Neligan, 6–1, 6–2; G. H. Hunt lost to H. G. Monteith, w. o.

Curle and Barber lost to Vernon and Luker, 1–6, 3–6; beat Powell and Willans, 13–11, 1–6, 6–4; beat Monteith and Neligan, 7–5, 6–1.

Covell and Hunt beat Powell and Willans, 1–6, 6–3, 6–3; beat Monteith and Neligan, 6–4, 6–1; beat Vernon and Luker, 1-6, 6–1, 6–4.

Roe and Lucas beat Monteith and Neligan, 6–2, 6–4; lost to Vernon and Luker, 3–6, 6–3, 3–6; beat Powell and Willans, 6–3, 6–1.

GUY'S v. ST. THOMAS'S.

FINAL.

A. S. Roe beat A. C. Gemmell, 6–3, 6–3; R. Curle beat A. D. Gardner, 6–4, 6–3; G. C. Covell beat G. N.

Brandon, 6–4, 4–6, 6–4; H. W. Barber lost to A. T. Rae, 2–6, 5–7; R. H. Lucas lost to Burt, 6–8, 9–11; G. H. Hunt beat A. R. Hargreaves, 6–2, 6–3.

Curle and Barber lost to Gemmell and Gardner, 4–6, 6–2, 8–10; beat Burt and Hargreaves, 6–3, 6–1; beat Rae and Brandon, 6–2, 10–8.

Covell and Hunt lost to Rae and Brandon, 2–6, 5–7; lost to Gemmell and Gardner, 5–7, 1–6; beat Burt and Hargreaves, 0–6, 6–1, 6–4.

Roe and Lucas beat Burt and Hargreaves, 6–3, 4–6, 6–1; beat Rae and Brandon, 6–3, 7–5; lost to Gemmell and Gardner, 3–6, 4–6.

JUNIOR INTER-HOSPITAL CUP TIES.

Guy's 2nd VI. beat London 2nd VI. in the first round at Honor Oak Park on Thursday, June 23rd, by nine matches to one, 19 sets to 4, 130 games to 70.

G. W. King beat W. Grant, 6–2, 5–7, 6–2; H. L. S. Griffiths beat C. Gibson, 6–3, 6–1; R. H. Lucas beat T. Batchelor, 6–1, 6–0; H. S. Groves beat J. S. Gabe, 7–5, 6–3; L. Price Harris lost to L. Sainsbury, 6–4, 3–6, 4–6; R. Farrington beat H. Seeley, 6–1, 6–1.

Lucas and Griffiths beat Grant and Gibson, 7–5, 2–6, 6–4.

Harris and Groves beat Gabe and Sainsbury, 6–4, 6–3.

King and Farrington beat Batchelor and Seeley, 6–1, 6–1; beat Gabe and Sainsbury, 6–1, 6–3.

GUY'S 2ND VI. v. MIDDLESEX.

Guy's 2nd VI. beat Middlesex in the semi-final on June 24th by eight matches to two; 18 sets to 7, 145 games to 8.

G. W. King beat C. Vivian, 6–4, 4–6, 7–5; H. L. S. Griffiths beat G. Laurence, 7–9, 6–3, 6–3; R. H. Lucas beat O. L. Gould, 6–1, 4–6, 7–5; H. S. Groves beat R. C. James, 6–3, 6–1; L. Price Harris beat A. T. Willan, 6–4, 6–1; R. Farrington beat L. J. Gosse, 6–2, 6–1.

Griffiths and Lucas lost to Laurence and Vivian, 2–6, 6–4, 8–10; beat Willan and Gosse, 6–1, 6–1.

Price Harris and Groves lost to Gould and James, 3–6, 7–5, 6–8.

King and Farrington beat Willan and Gosse, 6–1, 6–2.

GUY'S 2ND VI. v. ROYAL DENTAL HOSPITAL.

FINAL.

This match was played at Honor Oak Park on July 4th, and resulted in a victory for us by nine matches to six, 194 games to 181, 20 sets to 18. The team are to be heartily congratulated on their success for the third consecutive year. Lucas and Griffiths showed good form throughout, but King and Farrington greatly distinguished themselves in winning all their doubles, and the latter all his singles during the three days' play. Groves also was seen to advantage.

G. W. King lost to Matthews, 4–6, 4–6; H. L. S. Griffiths beat Jackson, 7–9, 6–0, 6–1; R. H. Lucas beat List, 6–4, 2–6, 6–4; H. S. Groves lost to Lewis, 5–7, 6–4, 6–8; L. Price Harris lost to Beckett, 7–9, 3–6; R. Farrington beat Blundell, 6–3, 7–5.

Lucas and Griffiths beat List and Jackson, 6–3, 6–4; beat Matthews and Beckett, 1–6, 6–2, 6–2; beat Lewis and Blundell, 6–4, 6–8, 6–2.

Groves and Price Harris lost to Matthews and Beckett, 3–6, 1–6; lost to Lewis and Blundell, 3–6, 4–6; lost to List and Jackson, 4–6, 6–2, 2–6.

King and Farrington beat Lewis and Blundell, 6–3, 3–6, 10–8; beat List and Jackson, 6–2, 3–6, 7–5; beat Matthews and Beckett, 6–2, 6–2.

Appointments.

Civil.

DOHERTY, J. W., L.D.S. Eng., has been appointed Assistant Dental Surgeon to the Kensington and Fulham General Hospital.

ISAACS, D., M.R.C.S. Eng., L.R.C.P. Lond., has been appointed Third Resident Assistant Medical Officer of the West Ham Union.

Naval and Military.

Fleet Surgeon W. W. PRYN, R.N., has been appointed to the *President*, additional, for three months' hospital course.

Staff Surgeon J. G. WATT, R.N., has been appointed to the *King Alfred*.

Major E. M. PILCHER, D.S.O., R.A.M.C., at present serving in the Straits Settlements, has been selected to succeed Major C. G. SPENCER as Professor of Medical Surgery at the Royal Army Medical College.

Captain H. C. KEATES, I.M.S., and Captain H. D. PEILE, I.M.S., have arrived home on leave from India.

Territorial Force.

For attachment to a Unit other than a Medical Unit—Surgeon-Major HARRY POOLE BERRY, from the 4th Battalion, The Lincolnshire Regiment, to be Major, with precedence as from September 13th, 1902 (dated June 25th, 1910).

West African Medical Staff.

C. E. S. WATSON, M.R.C.S. Eng., L.R.C.P. Lond., Medical Officer, Northern Nigeria, to be Senior Medical Officer, Northern Nigeria.

Marriage.

ROBSON—PERCIVAL.—On Wednesday, June 8th, at All Saints Church, Northampton, by the Rev. J. Cunningham, assisted by the Rev. Canon L. T. Jones and the Rev. R. M. Sarjeantson, William Morton Robson, M.D. Lond., M.R.C.P., of 73, St. Giles Street, Northampton, to Daisy, younger daughter of G. H. Percival, Esq., M.B., of 66, Abington Street, Northampton.

Ed.—A. N. C.

GUY'S HOSPITAL GAZETTE.

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Passim.

THE *Southwark and Bermondsey Recorder*, in an otherwise excellent report of the Garden Party, in the course of which are several appreciative references to the good work done by Guy's Hospital for South London, makes the following amusing blunder :—

> "The visitors inspected the various special buildings, including the chapel, wherein is to be seen a monument to his memory, memorials to Sir Astley Cooper, Sir William Gull, Dr. Hale White, Senior Physician, Mr. Symonds, Senior Surgeon, and others, including the Right Hon. W. E. Gladstone, who for upwards of half a century was one of the Governors."

THE KING has been pleased to appoint Sir Alfred Downing Fripp, K.C.V.O., C.B., F.R.C.S., to be an honorary Surgeon-in-Ordinary to His Majesty.

MR. C. M. PLUMPTRE has been appointed Resident Medical Officer in Bright Ward, to fill the vacancy caused by Mr. Trethowan's resignation and appointment as Resident Surgical Officer. The recent great increase in the work of the Throat Out-patient Department has led the authorities to establish a second Clinical Assistantship in this department, and Mr. T. B. Layton has been appointed to this post.

THE following is the list of officers and other members of the Council of the Royal Society of Medicine who have been elected at the Annual General Meeting for the Society's year beginning on October 1st next :—President : Sir Henry Morris, Bart. Hon. Treasurers : Sir William Selby Church, Bart., and Sir Francis H. Champneys, Bart. Hon. Librarians : Mr. Rockman H. Godlee and Dr. Norman Moore. Hon. Secretaries : Dr. Arthur Latham and Mr. Herbert S. Pendlebury. Other members of the Council : Sir William Allchin, Dr. W. P. Herringham, Mr. H. T. Butlin, Mr. D'Arcy Power, Dr. R. A. Gibbons, Dr. H. D. Rolleston, Mr. J. Warrington Howard, Mr. Charters J. Symonds, and Mr. E. F. White.

THE recent election of four Fellows on to the Council of the Royal College of Surgeons has a general rather than a particular interest for Guy's men, as we had no representative among the candidates. With a Guy's man as one of the vice-presidents, and three Guy's men as members, we are at present as fully represented on the Council as we can hope to be. There were five candidates for the four vacancies, and they received votes as follows :—Mr. C. B. Lockwood, 532 ; Mr. Bilton Pollard, 514 ; Mr. John Bland-Sutton, 499 ; Mr. C. A. Ballance, M.V.O.,

484; Mr. J. E. Lane, 313. The first four were accordingly elected.

IT is not often that the newspaper placards or the advertisement headings really bring one a glad message, but we have recently noticed some which did. *John Bull* issued a placard as follows:—"NURSING" AND "MASSAGE" HOMES (CONCLUDED), the final word of which must have made many breathe a sigh of relief. Then, again, we have seen a Macaura advertisement headed:—"THE DOCTOR-INVENTOR SAYS HE HAS ALREADY OVER-STAYED THE TIME ALLOWED FOR HIS VISIT TO LONDON." So, after all, there *is* a limit.

As an example of the depths to which snobbishness can go, we note the following:—"At a meeting of the Coventry and Warwickshire Committee objection was raised by representatives of the Hospital Saturday Working Men's Committee to the words 'men and women' being placed over the entrances in the new Out-patient department, for which the Workmen's Committee had raised the money. It was contended that these words gave an impression of class distinction, and should be altered to 'ladies and gentlemen.'" (!)

IN the list of distinguished men and women, most of them famous in science or art, who have been awarded pensions in the new Civil List, details of which were recently issued, there stands the name of Mr. Thomas Bryant, F.R.C.S. We welcome this recognition of Mr. Bryant's services towards the advancement of surgery, and in a general sense we rejoice that the State should in some measure, though she can never do it other than inadequately, repay her great debt of gratitude to those veterans of science and art and literature who have taken their part in shaping the moral and intellectual history of the age in which they lived. Those who have served their country in statesmanship or in war are never likely to be forgotten by their State. Those who have grown old in the humbler sphere of manual labour are now, too, secure of recognition and support in their last years. But there is always a risk that the State may overlook those rarer servants who have served her, not in arms or commerce or physical toil, but in the career of intellectual advancement, equally noble, and so frequently a greater power for her progress and security, and yet so frequently ill-requited in a worldly sense. The Civil List Pensions are a symbol of the country's tribute to her old and respected servants.

IT is over a year since we have had to record the occurrence of a fire near the hospital. Great excitement was caused in the hospital late last Monday night by a rumour that the Laundry was on fire. This happily proved to be untrue, and the fire was found to have arisen in a building next to the laundry, a lofty warehouse rented by Messrs. Tabrum & Son, Hop Merchants, in the Talbot Yard, Borough High Street, close to the inn where Mr. Pickwick had his first momentous meeting with Sam Weller. There was fortunately very little wind, otherwise there might have been considerable danger to some of the hospital buildings. In response to a brigade call, numerous fire-engines arrived on the scene, and were successful in getting the fire under control, but not, however, until considerable damage, estimated at £10,000, had been done. One fireman was injured, and had to be treated in the hospital. From the laundry windows some of us had an excellent view of the firemen's and Salvage Corps men's operations. The columns of dense smoke, the powerful jets of water flowing back into the roadway laden with hops, and the flare of the acetylene lamps, made a strikingly picturesque scene.

WE sincerely regret to announce the death, on July 6th, of Dr. William Frank Hearnden, M.R.C.S., L.R.C.P., of Sutton, formerly of Guy's. The funeral was held on July 11th at the Parish Church, Sutton, and was attended by Dr. Goodhart and Mr. Symonds, as well as by many local medical men. Dr. Hearnden was in his fifty-fourth year; his death, due to angina, was tragically sudden. Only four days before, he had attended the Guy's Biennial Dinner, and was then apparently in good health. A friend

who sat next to him on that occasion has related some reminiscences of him elsewhere in this issue of the Gazette. Here we can only express our deep sympathy with his widow. In the neighbourhood of Sutton, where he had gained the affection of both rich and poor, and where he was known as "Dr. Willie," his loss will be severely felt. A proposal is on foot to endow a cot in his memory at the local cottage hospital.

Appointments.

Medical School Appointments.

The following appointments have been made by the Treasurer upon the recommendation of the Medical Council:—

Clinical Assistants in the Medical Wards.—Messrs. A. Neville Cox (Dr. Hale White); J. M. Jarvie (Dr. Pitt); A. M. Bodkin (Sir Cooper Perry); A. E. Rayner (Dr. Shaw).

Ophthalmic Dressers.—Messrs. E. A. Penny, A. H. Birks (Mr. Eason, August 1st); G. T. Mullally, W. P. Vicary (Mr. Ormond, August 1st); L. Milton, R. Heaton (Mr. Eason, September 16th); G. C. Lowe, T. S. Sharpley (Mr. Ormond, September 16th).

Surgeons' Dressers.—Messrs. J. L. M. Symns, G. Covell, F. Cook, E. G. Schlesinger, C. A. R. Gatley, C. Aldis (Mr. Symonds); W. E. S. Digby, A. C. L. D'Arifat, S. S. Crosse, V. Glendining, W. J. D. Smyth, G. B. H. Jones (Mr. Lane); H. G. Crawford, H. L. Hopkins, P. Smith, W. M. Langdon, R. C. Poyser, J. L. Stewart (Mr. Dunn); P. J. Watkin, H. N. Eccles, F. N. Doubleday, Jap Ah Chit, C. F. Constant, W. S. Hyde (Sir Alfred Fripp).

Externs.—Messrs. H. W. Barber, A. Seabrooke, R. Heaton, J. H. Campain, H. V. Leigh (August); A. Sandison, H. L. S. Griffiths, A. C. Jepson, H. Daw, C. M. Ryley (September); N. Mutch, A. J. McNair, E. C. Peers, E. G. Reeve, H. H. Davis (October).

Naval and Military.

Fleet Surgeon C. M. Beadnell, R.N., has been appointed to the *Fishgard*, 13th July.

Staff-Surgeon S. Croneen, appointed to the *Bulwark*, temporary, for the manœuvres.

Colonel H. J. W. Barrow, A.M.S., is placed on retired pay.

Captain J. Matthews, R.A.M.C., has been posted to Karachi.

Lieutenant-Colonel E. Christian Hare, I.M.S., Sanitary Commissioner, Assam, has been granted nine months' extension of his leave from India.

Captain P. S. Mills, M.B., I.M.S., 5th (Mhow) Division, has been appointed Specialist in Electrical Science.

H. L. Duke, M.B., B.C. Cantab., has been selected for temporary employment as a Medical Officer in Uganda.

Dental Notes.

It is not always that the great worth of our hospital is fully appreciated, hence we have much pleasure in reproducing a letter recently received by a member of the Dental Staff:—

July 4, 1910.

Dear Dr. ———

Please excuse my not having answered your letter before, and to thank you for your kindness in having helped my servant to the excellent treatment she received in Guy's Hospital. In addition to the teeth being attended to, she was also treated for Bell's paralysis which she had suddenly contracted through a chill. The treatment was most effective and she was quickly cured.

I enclose P. O. for two pounds, and should be much obliged if you would add to your kindness if you would allot one to the Dental Department and the other to the Department where she was treated for Bell's paralysis, or if that is not feasible, to give it to the general Hospital fund.

Please excuse my giving you this trouble.

Yours truly,

———

From the Gazette's Special Pathologist.

All specimens—particularly those of solid tissues—should be accompanied, if possible, by a short clinical and post-mortem history, and a postal order for 2s. 6d. An extra charge of 6d. per slide is made when prepared sections are to be forwarded.

Diphtheria specimens are to be labelled *Immediate*.

Specimens, Letters, and Postal Orders should be addressed to the Manager, Gazette Office, Guy's Hospital.

NOTICE.

G. F. S., Kennington Road.—This is a difficult specimen, owing to extensive caseation and post-mortem changes. We have no doubt, however, that the lesions are secondary malignant growths. The general arrangement, seen best in the liver, is that of a small-celled carcinoma, but there is no definite evidence as to its primary source. The lung shows tubercles, which, of course, are independent lesions.

PATHOLOGIST.

Annual Prize Day and Garden Party.

ON Thursday, July 7th, when this function took place, the weather was somewhat dull, but fortunately no rain fell during the afternoon. There were no "aqueous downpours," as a contemporary picturesquely describes it, and, on the whole, perhaps the weather may be counted good, judging it by 1910 standards.

The Governors and Staff assembled in the Court Room at 3.45, to meet Professor Howard Marsh, and then proceeded to the Medical School Buildings, where the Distribution of Prizes took place.

VISCOUNT GOSCHEN, the Treasurer of the Hospital, occupied the Chair. In opening the proceedings, he said that as that was the first opportunity he had had of appearing in public as Treasurer of the Hospital, he wished to trespass on the kindness of the company for a moment while he said a few words. It was to take the opportunity publicly of expressing his high appreciation of the great compliment which his colleagues had paid him in electing him Treasurer of the Hospital. He would also like to assure all those who were interested in the Institution of his earnest desire to do all he could to further its interests in the future. (Hear, hear.) He was sure that all who had been present on previous occasions when Mr. Cosmo Bonsor had presided at the function, must feel deep regret at his absence that afternoon. But he was sure those present would comfort themselves with the same thought which he had, namely, that although Mr. Bonsor was no longer Treasurer, he had only been transferred from one post to another in the Hospital, and he was sure Mr. Bonsor's advice and assistance would always be at its service in the future as it had been in the past. (Applause.) All knew the great services which Mr. Bonsor had rendered to the Hospital, how with untiring energy and constant kindliness he had devoted himself to its welfare, and had done all that was in his power to further its interests. He had set a very high example, and he, Viscount Goschen, could only assure his hearers that he would do his utmost to follow it, though he was afraid he might fall far short of the mark. But he hoped that in his work he might count upon the same support of the Staff of the Hospital which they had so generously given to Mr. Bonsor during his tenure of that office. (Applause.) He concluded by asking the Dean to read the report.

Mr. H. L. EASON (Dean of the School) read the report as follows:—

THE DEAN'S REPORT.

THE progress of the Medical and Dental Schools during the past year continues satisfactory, and requires but little comment. The entry of students has not been quite up to the average of preceding years, but the School Staff are satisfied that Guy's still obtains its due proportion of the students who come to London for their medical education. Figures supplied to the Senate of the University of London for presentation to the Royal Commission on University Education in London show, in a striking manner, the wide field from which Guy's Hospital attracts students. Of 509 students now attached to the School, 239 come from within the radius of thirty miles from the University, 202 come from parts of the United Kingdom outside the University radius, 47 come from British Dominions, excluding the United Kingdom and India, 7 from India, and 14 from foreign countries.

The number of students who qualified was greater than that of the preceding year. At the University of Oxford 1 student obtained the degree of Bachelor of Medicine and Surgery; at the University of Cambridge 2 students took the degree of Master of Surgery, 7 took the degree of Doctor of Medicine, and 14 qualified as Bachelors of Medicine and Surgery.

At the University of London 3 students obtained the degree of Doctor of Medicine, and 15 qualified as Bachelors of Medicine and Surgery. In addition to these University degrees, 49 students gained the Conjoint Diploma granted by the Royal Colleges of Physicians and Surgeons, and 2 received the Diploma of Fellow of the Royal College of Surgeons of England. In the Dental School the entry shows a considerable increase over that of the previous year, and 30 students were granted the Licence in Dental Surgery of the Royal College of Surgeons of England. Three Guy's men have entered the Royal Army Medical Corps, 2 the Naval Medical Service, and 2 the Indian Medical Service.

The School has to congratulate Mr. H. I. Janmahomed on obtaining the University Gold Medal in the examination for the M.D. London, and Messrs. Duvivier, Peall, and T. D. M. Stout in obtaining Honours in various subjects at the M.B., B.S. examination.

There have been few changes on the Hospital and School Staff, and those that have been made are chiefly in consequence of the institution of new Special Departments. Acting upon the advice of a Committee appointed to consider the whole subject of Specialism and its relation to Medicine and Surgery, the Governors have decided to create new Special Departments for Diseases of the Genito-Urinary System, Nervous Diseases, and Diseases of Children. It has been decided, in addition, that in future the Departments for Diseases of the Throat and Ear shall be in the charge of pure Specialists, and not, as heretofore, of Assistant Surgeons on the General Staff. To fill the vacancies caused by the institution of these new Special Departments, Mr. W. M. Mollison has been appointed Surgeon in charge of the Aural Department, and Mr. A. R. Thompson has been appointed the first Surgeon in charge of the Department for the treatment of Diseases of the Genito-Urinary System. Dr. Hertz has been appointed Physician in charge of the Department for Diseases of the Nervous System, while at the present time the post of Physician in charge of the Department for Diseases of Children remains vacant. To fill the vacancy caused by the promotion of Mr. Mollison to the Hospital Staff,

Mr. T. B. Layton has been appointed Demonstrator of Anatomy, and Mr. Townrow has been appointed Surgical Registrar in place of Mr. Layton. Mr. Trethowan succeeds Mr. Lobb as Resident Surgical Officer, and Mr. Zorab has been appointed Ophthalmic Assistant to fill the vacancy caused by the resignation of Mr. Bergin. Dr. Shaw has resigned the appointment of Honorary Librarian to the Wills Library, and Dr. French has been elected to succeed him in this post.

The rebuilding of the Chemical and Physical Laboratories, the result of the necessity for additional accommodation owing to the expansion of the Dental School, has been commenced, and it is hoped that the Laboratories will be available for the use of students during the coming year. Directly this accommodation is provided, the Dental School will occupy the space vacated by the old Laboratories, and more ample room will be provided for the requirements of dental students and pupils. The number of the latter has increased so quickly since the institution of a system of mechanical pupilage four years ago, that it has been found necessary to increase the Laboratory staff by the appointment of two additional Demonstrators, an additional mechanic, and two laboratory boys.

The new Out-Patient Department, which was opened in October of last year, has proved of the greatest benefit both to the Hospital and the School, and there is now sufficient accommodation for any increase of work that the proper service of the Hospital or the requirements of medical education may render necessary.

The Hospital and School Staff have heard, with extreme regret, of the resignation of the Treasurer, who, as head of the Medical School, has been responsible for its success for the last fourteen years. They wish to place on record their most sincere appreciation of his unremitting care and attention to their interests during the whole of that period, and their gratification at his appointment to the post of President of the Hospital, in place of His Majesty the King, who, on his accession, has been obliged to resign from this office. Mr. Bonsor's continued connection with the Hospital and School in this capacity to some extent mitigates the sense of personal regret which has been felt by every member of the School Staff at losing his most valued counsel and direction.

It is again necessary, as in previous years, to make a further appeal for the endowment of Medical Education and Research. It is now well recognized that the science of Medicine is so complex, the field of investigation so wide, and the curriculum of the student so full, that it is impossible to maintain a Medical School at the proper standard of efficiency from the income derived solely from students' fees. In this respect the Medical School attached to Guy's Hospital has been comparatively fortunate, as, owing to the number of its students and the association of its Dental and Medical Schools, its resources have been equal to the requirements of modern education, though at the cost of considerable financial sacrifice on the part of every member of the School Staff. The School has to acknowledge the munificence of many benefactors, who, by the endowment of studentships or lectureships in recent years have assisted the progress of medical education, and by their example have stimulated others to similar endowments for the prosecution of research. Much more, however, remains to be done; the School can only once more ask for assistance to maintain it in a manner worthy of its history and traditions, and to compete successfully with other Provincial and Foreign Schools which are more amply provided for by a public spirit which appears so difficult to arouse in the Metropolis.

The Chairman then invited Professor Howard Marsh to distribute the prizes, the list being as follows:—

LIST OF MEDALLISTS AND PRIZEMEN.

OPEN SCHOLARSHIPS IN ARTS.—Henry Francis Thomas Hogben, Bedford Grammar School, William Morris Lansdale, St. Olave's and St. Saviour's Grammar School, equal £50 each. Ames Kyle, Shrewsbury School, £50.

OPEN SCHOLARSHIPS IN SCIENCE.—Charles Hamilton Gould, Preliminary Science Class, Guy's Hospital, £150. James York Moore, Preliminary Science Class, Guy's Hospital, £60. Cyril Henry Edwards, St. Paul's School, West Kensington, Allan Noel Minns, Thetford Grammar School, equal Certificates.

SCHOLARSHIP FOR UNIVERSITY STUDENTS. — Trevor Braby Heaton, B.A., Christ Church, Oxford, £50.

OPEN SCHOLARSHIPS IN DENTAL MECHANICS.—October, 1909, Reginald Gilbert Farrington, Douglas Wain, equal £10 each. May, 1910, Charles Henry Housden, Edgar Roskelly Williams, equal £10 each.

JUNIOR PROFICIENCY PRIZES.—John Frederick Gwyther Richards, £20. Oscar Reginald Lewis Wilson, £15. George Sefton Miller, William Robinson, equal £5 each.

THE BEANEY PRIZE FOR PATHOLOGY (1909). — Albert Harold Godwin Burton, £34.

THE BEANEY PRIZE FOR PATHOLOGY (1910.) — John Godfrey Saner, Alan Herapath Todd, equal £17 each. Geoffrey Dunderdale, Certificate.

THE MICHAEL HARRIS PRIZE FOR ANATOMY.—John Frederick Gwyther Richards, £10.

THE HILTON PRIZE FOR DISSECTIONS (1910).—Skene Keith, William Leslie Webb, equal £2 each. John Frederick Gwyther Richards, £1.

THE SANDS COX SCHOLARSHIP IN PHYSIOLOGY.—George Sefton Miller, William Robinson, William Leslie Webb, equal £5 each.

FIRST YEAR'S PRIZE IN DENTAL SUBJECTS.—Guy William Enston Holloway, Isidore Gittleson Samuels, Reginald Douglas Tanner, equal, £3 6s. 8d. each.

SECOND YEAR'S PRIZE IN GENERAL SUBJECTS.—Alfred Thomas Rycroft, £10; Harold Harrison, Edward Palmer Hudson, equal certificates.

PRIZE FOR OPERATIVE DENTAL SURGERY.—John Hargrave Rhodes, £10.

NEWLAND-PEDLEY GOLD MEDAL FOR PRACTICAL DENTISTRY.—Harold Harrison.

GOLDING-BIRD GOLD MEDAL AND SCHOLARSHIP IN BACTERIOLOGY.—Arthur Neville Cox, £20; Albert Harold Godwin Burton, Certificate.

THE OLDHAM PRIZE IN OPHTHALMOLOGY.—Harold Gardiner, £30.

TREASURER'S GOLD MEDAL FOR CLINICAL MEDICINE.—Thomas Duncan Macgregor Stout.

TREASURER'S GOLD MEDAL FOR CLINICAL SURGERY.—Harold Gardiner.

THE ASTLEY COOPER PRIZE.—Professor E. H. Starling, M.D., F.R.S., £300.

PROFESSOR MARSH'S ADDRESS.

I had the greatest pleasure in accepting the invitation—couched in very seductive terms—of your Dean that I should present the prizes to day. At first the proposal that a Bart.'s man should perform this interesting function might seem incongruous, for are not Guy's and Bart.'s two rivals who always regard each other with enmity and jealously? But to those who know the facts this idea is a pure absurdity. The relation of the two has always, no doubt, been one of keen competition, but this has always been healthy and completely friendly. Guy's and Bart.'s along with St. Thomas's—the three Royal Hospitals—have constantly stood shoulder to shoulder as comrades who understand and respect each other. All the Seniors know what Bart.'s has thought of Astley Cooper, Hilton, Wilks, Gull, Moxon, and Fagge, and what Guy's has thought of the big guns at St. Bart.'s. These men have been a common possession. One may even say that every Bart.'s man has been a student at Guy's, and every Guy's man a student of Bart.'s. There is, therefore, no reason why I should not be here to-day, and I assure you I feel greatly honoured by your confidence. Now, you who are students will expect me to have something to say as to what I think of your choice of a profession and your chances of success, and I must add something on my own account as to the very grave responsibilities you have undertaken. I can say without hesitation that the profession affords you ample opportunities, while it is for you to note that your future depends very largely on yourselves. Two externals you must hope for, you cannot succeed without them—good health and good fortune. It is a mere platitude that life is a succession of lotteries. I strongly believe in good and in bad luck, but let it be remembered that both can be largely influenced by a man's conduct. He who would avail himself of good luck must be close upon its heels and ready to use the chance when it comes. As you know, there is a tide in the affairs of men which taken at the flood leads on to fortune. You must not be like the foolish Virgins who had no oil in their lamps. In these days even they have taken the matter seriously in hand and can no longer be termed foolish in the original sense. Remember that if ill-luck comes it may be the making of you. A tumble may do you a world of good; or, by being turned, by what you regard as ill-luck, out of a road that would have led nowhere, you may be diverted into one that brings you to full success. Whatever happens never give in, never say die; in Huxley's phrase, "it is dogged as does it." And many a man has given up when, although he did not know it, he was close to the winning post. One thing you will require above all others, that is character—a general name for a number of qualities which must be constantly cultivated and developed—a sense of duty and of responsibility, kindness, sympathy, and magnanimity, in the largest meaning of that term. You cannot have too much of any one of these. Another requisite on your part is honest hard work, based on an intelligent estimate of the direction which hard work should take. My own life has been spent in hard work, and I don't know what I should do without it, but I fear I should become a neurotic and have to appeal to Christian Science to cure me. The way to be happy is to be fully employed in some congenial work. Surely your profession supplies opportunities for this. You will be working in a field rendered interesting by the great advances which are being made, so that the weapons with which you are fighting are constantly becoming more efficient, so that you can always be going "one better."

Those among you who feel that if only you had a good start you could do great things should know the history of some of our greatest men, the large majority of whom have started at the foot of the ladder and have climbed from the bottom to the top, often sighing out the poet's words—

> "Ah, who can tell how hard it is to climb
> That steep where fame's proud temple shines afar."

As to money to start with, do not covet it, for it may easily be your ruin. I knew a man who had £200 a year when he was twenty-one, and he never did anything. If you marry, mind you insure your lives, not for self-protection but in duty to those who have claims upon you.

Now as to Medicine. Medicine has been entirely recast in the last twenty years; it no longer consists in the narrow task of treating individual patients for some unknown disease and prescribing a series of drugs reputed to be remedies, in the hope that one of them may hit the nail on the head. I am not speaking in any disrespect of the past; I am only saying what the past has been. Medicine has now become by natural evolution a department of biology. It tries first to obtain a knowledge of the normal in structure and function, and then to trace out the agencies which produce the abnormal, and ascertain the means by which the abnormal may be eliminated or counteracted so that the normal may be re-established. Now it is not too much to say that Medicine has given a powerful impulse to the study of biological science. At every stage of the inquiry into the nature of the disease questions of the widest and most fundamental character have cropped up and have led investigators into fresh districts, especially in chemistry, and challenged them to cultivate new methods of research. And what is the result? The result has been the discovery of a new world, the world of micro-organisms, a world of whose existence nothing was known until the days of Pasteur and Lister. And what a marvellous world it is. It is peopled by forms of life before which

the varieties of the human race fall into utter insignificance, whose numbers transcend the power of the human mind to reckon them, and whose minuteness is such that not a few of them are invisible under the strongest microscope which we now possess. And their influence on other forms of life, including ourselves, fills us with amazement. We now know that, setting aside degenerations—changes comparable with the changes which ensue when the tissues wear out as age advances—by far the greater number of diseases are due to the presence of micro-organisms. From an eruption on the scalp of a child or from a decayed tooth to tuberculosis, which causes one death in every ten that occur in England, to plague, cholera, yellow fever, malaria and sleeping sickness the story is the same, and in every case alike the question arises, what can be done? This question has called forth an effort which I should say is unparalleled in the field of research, and in which a multitude of skilled workers in Biology and Chemistry have taken part, and have striven as one man to contribute something to its solution, and everyone knows that the success already attained has transcended the anticipations of the most sanguine, and gone far to realise Tennyson's conception of the fairy-tales of Science. We now see that many of the most destructive diseases of man and of the lower animals are being wiped out, while it appears certain that the rest will in the course of time be got rid of. To take a single illustration—is there any reason to doubt that in the next thirty years tuberculosis, which now in England causes the death of 70,000 people every year, and the spoiling of the lives of probably twice as many more, will be entirely swept away? Well, this is what Medicine is at the present day, and can you doubt that if you are in earnest you are right in having joined its ranks?

In connection with the progress which has been made in Medicine, of course including Surgery, there is a question which is at the same time difficult and in the highest degree important—I mean that of research, and the methods by which research should be conducted. Now what is science but the acquisition of facts? The term is derived, as all are aware, from the Latin *scire*, to know. Thus every fact which is acquired is an advance in science, however simple and rudimentary it may be. The man who was the first to look into a rotten apple and find a grub had ascertained a new fact, and thus added to knowledge, so that he was, however humble the occasion, a scientific man. He had traced an effect back to its cause, and was able to see that to save his apple he must keep out the grub. It is the same all the world over. The scientific man is the man who searches out facts. John Hunter said, "Don't think; go and see," meaning, first get your facts and then think about them. You will remember the receipt for cooking a hare—first catch it. Now when you turn to Medicine and see that disease has supplanted health—in other words, that some disturbing agent has displaced the normal and substituted the abnormal for it—obviously the first step, as in the apple and the grub, is to learn what the disturbing agent is. We must therefore make ourselves the disciples of Harvey, Newton, and Darwin, and begin with research. This has been done, and the result is one of the marvels of our time. Research has disclosed the nature of tuberculosis, malaria, yellow fever, and sleeping sickness, and a large number of the diseases which are common amongst ourselves, diphtheria, pneumonia, abscesses, typhoid fever. Is not this a promising start? Then comes the question, How is research to be carried out? Can the man in the street tell us this? Could he have told Harvey, Faraday, Darwin, or Huxley? Is any man who knows nothing of biology or of the methods of scientific research in a position to interfere? Has he ever saved a human life, and is he ever likely to do so? Can he deny the value of the discoveries which I have mentioned, or tell us how they could otherwise have been made? How is he justified in bringing charges of inhumanity and cruelty, and saying that what is being done in research ought to be put down by the strong hand of the law? I remember that a lady wrote to that great high-minded and most kind-hearted man, Sir James Paget, that she was praying that heaven would consign him to the blackness of darkness for ever. Should not every fair-minded and intelligent person cry shame to this? Let me quote a sentence from a speech recently made by one of the ablest and most distinguished men of the day, the Bishop of Oxford, who, by a strange coincidence, is Sir James Paget's son. He said, "There is no truer patriotism than that of the man of science who bends his energies indefatigably to the liberation of his country from disease." When the public know what advances have been made, and are told by such men as Lister and Paget that they have been gained by the only method by which they could have been achieved, who is competent to contradict them, and when it is understood that what is done is done under Government supervision, and that no man can perform an experiment without a special licence, will not the public be satisfied that the matter is in safe hands? Will they not go further, and thank those who, at infinite pains, are doing them this great service, and will they not extend to them their full confidence and support?

Dr. HALE WHITE (Senior Physician to the Hospital), said it was a pleasant task which had fallen to his lot, that of proposing a vote of thanks to Professor Howard Marsh for having kindly attended, and for having distributed the prizes so graciously and delivered such a good address. To the elders present that day Mr. Marsh was known as a kind friend; to the younger people he was known as a genial companion across the examination table. (Laughter.) Most of them would remember John and Thomas, and how the Autocrat of the Breakfast Table explained to Benjamin Franklin that there were at least three Johns and three Thomases. There were more than that to be considered in connection with Professor Marsh, so many that they could hardly be taken that afternoon. He came among them as the representative of the University of Cambridge. Guy's Hospital and School were closely bound up with that University. The gentleman who distributed the prizes

last year, the Duke of Devonshire, was well known to have many attachments to the University of Cambridge. For nearly two hundred years there had been a constant stream of distinguished persons from Cambridge to Guy's Hospital. Many of its most distinguished physicians and surgeons had come from that University, and so had many of its most distinguished students. He had no doubt they would continue to come, and in increasing numbers. But there was discernible an indication of a movement in the other direction. Professor Howard Marsh and he had a mutual friend, one of the chief ornaments of Cambridge, who was educated at Guy's entirely, and he had heard that he had recently attained the distinction of a Fellowship of Trinity. Now it was not only in intellectual matters that there was that pleasant current of exchange between Guy's and the University of Cambridge, for even in sport every year Guy's played the University at football, and sometimes, he was glad to say, Guy's beat them, perhaps more often than not. (Laughter.) That of the Cambridge Professor was one aspect of Professor Howard Marsh. There was another aspect also of which the Professor himself had reminded the company. He represented a great hospital, St. Bartholomew's. The bond between these two hospitals was that they both had long traditions to look back to and live up to. Everyone there, and everyone at Guy's, in everything that he did, considered, "Am I doing it as well as my ancestors would have done it?" It was that which kept him up to the mark. Indeed, St. Bartholomew's was specially interesting to them at Guy's, because every Guy's man felt that if by any much-to-be-regretted misfortune he were unable to be a Guy's man, he would choose to be a Bartholomew's man. (Laughter.) It was interesting that Professor Howard Marsh was distributing the prizes that afternoon, because in the last week he (the speaker) had met a gentleman who was a colleague of Professor Marsh's at St. Bartholomew's, who said to him that on the previous night he had had a most extraordinary dream; he could not decide in the dream whether it was preferable to be at Guy's or at Bartholomew's. And the subject was so distracting that it nearly drove him mad, and it was a relief when he woke up and found that it was decided. He did not say so, but his expression indicated that he was sorry it was decided that he was not a Guy's man. Those were two aspects of Professor Howard Marsh. The last he would mention was Professor Howard Marsh himself. They all knew the man, well-known for his scientific distinctions in surgery. To take one point only, it was not many years ago that the question which raged very much in the technical world was as to the best way of treating a particular disease, namely, tubercular disease of the hip. There were two schools, one of which was led by Professor Marsh, and, as everybody knew, the school led by the Professor was right, and the other was wrong. Lastly, there was Professor Marsh as a friend, and they knew that he was a very true one. The commencement of his friendship with the Professor was that they found themselves many years ago admiring the same picture at the old Water Colour Society, so it would be seen they had similar tastes. On all grounds, therefore, he had very great pleasure in proposing a vote of thanks to him.

Mr. CHARTERS SYMONDS (Senior Surgeon) said he had very great pleasure in seconding the vote of thanks, partly for the opportunity it afforded him of emphasising our obligation to the Master of Downing for his presence that afternoon, also that in doing so he was offering the thanks of the audience to one whom he might call an old friend. For the address to which we all had listened with so much instruction and pleasure, he begged to thank Professor Howard Marsh in the name not only of those present, but of the students who would have the opportunity of reading it later on. Most men reaching the age when retirement from hospital duties and medical school obligations had arrived, seek some repose, or retire from active work, but instead they saw Professor Howard Marsh accepting the position of Master of an important College at Cambridge, and taking a leading part in the medical work of that University. Those who knew how he had identified himself with the life of St. Bartholomew's Hospital, and the active part he had taken in its Medical School, felt sure that the influence of the Regius Professorship of Surgery would be maintained on the lines laid down by his great predecessor, Sir George Humphrey. This expectation had been abundantly justified, for not only had Professor Howard Marsh identified himself with the Collegiate life as Master of his College, but he had maintained the level and breadth of the examinations. Many know the care he has taken in the selection of examiners—was not our old colleague Mr. Dunn one of that body? The influence had not, however, been all one-sided, for while as Professor of Surgery Mr. Howard Marsh had conferred benefits on Cambridge, he thought they might congratulate the Master of Downing on the excellent health in which he appeared to be. That might be the result of the calm of University life, or it might be due to the keen air of the Cambridge Fens; some, perhaps, might think it was the generous diet of the Master's high table. (Laughter.) Whatever it might be, he was sure that all, while tendering to the Master of Downing their best thanks for presenting the prizes, would unite in expressing the hope that the associations which at present existed between Professor Howard Marsh and the University of Cambridge might long continue. (Applause.)

The resolution having been carried by acclamation,

PROFESSOR HOWARD MARSH returned thanks for the very kind way in which the function had been conducted. He wished to say that coming there that day he counted as one of the honours of his life. He wished to heap upon them his thanks for having given him that great privilege. It had been very important to him, because his dear friends Hale White and Symonds had expressed what he hoped might be the thoughts of the company about himself. He would not abuse the opportunity by asking them to listen to any further remarks, and would

only say that the evidence of the bond which had been spoken of was very clear.

A large number of the visitors who were present took the opportunity during the afternoon of inspecting the Hospital and School Buildings. Refreshments were served in the Colonnade Quadrangles, and on the Terrace in the Park. The Royal Meister Orchestra, under the *baton* of M. Eugène Maney, played the following programme of music:—

1. March, "Gladiator's Farewell" (Blankenborgh); 2. Valse, "Septembre" (Godin); 3. Selection, "The Balkan Princess" (Rubens); 4. Humoresque (Dvorak); 5. *a.* Idylle, "Glow-worm" (Lincke), *b.* L'Extase (Thomè); 6. Valse, "Joys of Life" (Strauss); 7. Selection, "The Dollar Princess" (Fall); 8. Entr'acte, "Babillage" (Gillet); 9. Hungarian Dance (Brahms); 10. Petite Valse (Tschaikowsky); 11. Selection, "Tannhäuser" (Wagner); 12. Valse, "Weiner Berger" (Ziehrer); 13. Traümerei (Schumann); 14. March, "Le Regiment Favori" (Ertl).

Some Experiences of Bee-stings and Rheumatism.

"A COMIC CURE."—That is what the average person considers Bee-stinging for Rheumatism! When I spoke of trying the cure as an experiment to several medical friends, I noted a peculiar look in their eyes that clearly meant: "Do his friends know?" Now that I have given up experiments doubtless my medical friends think more hopefully of me. There is abundant evidence (to say nothing of tradition) to prove that persons frequently stung by bees are free from rheumatism. One striking case which I contributed to Dr. Ainley Walker's Report in the *British Medical Journal* on the subject is a good illustration.

Mrs. P., near Salisbury, suffered severely from rheumatism for ten years. She then kept bees, and was frequently stung, since when she has been entirely free from rheumatism, *i.e.*, for a period of twelve years. No medicine did her any good before, and her mode of life and place of living has been the same for twenty-two years.

The Reverend M. O. having suffered from rheumatism for years, and having undergone all kinds of treatment in the way of baths at Homburg and Bex, with little or no benefit, began in 1896 to keep bees, and "was often stung." In 1909 he wrote to me that since 1896 he has never had any rheumatism, being free for a period of seven years. It is right to add that this sufferer, while believing in the beneficial effects of the bee-stings, partly attributes his immunity from rheumatism to the "great perspirations from the honey I handled, and looking after the bees in very hot weather." I am inclined to agree with him. Many things may help a cure.

Mr. Cowan, the editor of the *Bee Journal*, tells me that an American friend of his never suffered from rheumatism so long as he kept bees, but that since giving up bee-keeping he suffers from the complaint. He gets rid of an attack, however, "by going among the hives and getting himself stung." There is no story of "sweating" in this case.

Dr. E. J. Burton, of Birmingham, has had considerable experience of the "cure," both personal and otherwise. He wrote to me that he presumes "the man who first introduced leeching met with a violent death in the primitive days of physic." This was apropos of the curious opposition to the cure by medical men.

Last year I made an experiment upon a man, aged 67, who had been suffering severely from rheumatism for a year in his left hip and leg. On June 23rd I applied five bees, and on 25th eight bees. On the 26th he reported that he had had a good night, and could turn over on his hip without pain. This was the first time for a year. I applied seven more bees, and the next day (27th) he had "no pain whatever." He continued to improve, and slept well. On July 30th he pronounced the result as "marvellous." Later I stung him at various intervals with more or less satisfactory results. Then each of us went for a holiday at the end of the summer, and on my return I found some one had persuaded him to try electrical treatment at the West London Hospital, which did him no good at all. He is rather worse now. If he wants more bee-stings he must live in the country and start a hive. I shall sting him no more. My impression is that he has adhesions between the nerve and sheath, and that something more drastic than even bee-stings will have to be done by surgery if he wishes for serious improvement. The interesting fact remains, that as long as he was under the stinging treatment he was much relieved.

Terc, of Marburg, keeps up the stinging in some cases for over a thousand stings. In my case I only gave fifty-four stings. The process involves considerable time and trouble if direct application of bees is made. I got my bees from Staffordshire by post in specially made boxes. It required some practice to catch the bees and apply them. At first I used Dr. Burton's bee forceps, and then, later, devised an apparatus

made with a test tube and glass slide, but, finally, I found the best way of all was with the gloved fingers. Bee catching is entirely a matter of practice. I used to let the bees out upon the window panes in the room and catch them there. It is safer, but with practice they can be caught as they emerge from the exit door of the box. In dealing with bees the great point is to be silent and move leisurely. Bees object to sudden movements and noise. But bees are not cowards like wasps. The latter will not attack a person who faces them. A wasp only stings a person who shows fear. Face a wasp who goes for you and he will fly away. A wasp is a coward, but an intelligent one.

In conclusion, I may express my opinion that the bee poison does exercise a curative action over rheumatism, but I doubt if personally applying the bees is worth all the trouble entailed. The length of time necessary for a cure seems to be quite indefinite. The pain of being stung is a distinct objection, though this varies a good deal in different people. Rheumatic subjects usually do not suffer from swelling and induration afterwards. I, personally, am an exception. Making various experiments upon myself I found the result decidedly unpleasant. The itching subsequently was very great. In my old patient, however, there was no reaction, all irritation disappearing by the next day. Formic acid is not the only ingredient of the bee secretion. There is "an alkaloidal base akin to the venoms," according to the researches of Calmette and others.

If the bee-sting cure appeals to any rheumatic person, I think the best thing for him or her to do is to keep bees, and by being stung occasionally the sufferer will obtain relief, and at the same time have the advantage of the stock of honey made.

FREDERIC VICARS, M.D.

London,
June 25th, 1910.

Papers by Guy's Men.

A. P. Beddard, M.A., M.D. Cantab., F.R.C.P. Lond.: Ochronosis associated with Carboluria (with plate).—*The Quarterly Journal of Medicine*, July, 1910.

Herbert French, M.A., M.D. Oxon., F.R.C.P. Lond.: Materia Medica for Nurses.—*The Nursing Mirror*, July 2nd, 1910.

Arthur F. Hertz, M.A., M.D. Oxon., F.R.C.P. Lond.: The Motor Functions of the Stomach: Part I., Physiology.—*The Quarterly Journal of Medicine*, July, 1910.

A Garden Party.

We arrived at the lodge and the drive leading up through the shady avenue of grand old elms to the mansion. Outside on the dusty road stood two policemen, who eyed us with evident interest as we drove in. Before reaching the house, we noticed a great crowd of well-dressed people wandering apparently aimlessly about, some with eyes on the ground, others gazing up into the trees, and all hurrying along, none taking notice of the other.

After a most delightful tea, we, too, started to wander in the pleasaunce. At once we were accosted by a lady, who, in anxious tones, besought us to say whether we had seen "a sow's ear"! Good Heavens!! In another moment an agitated gentleman stopped me to inquire did I know where "the cup and the lip" might be. Before long a third inquired in agonised tones if we could help her to find "nobody any good." And so the afternoon wore on. Every minute or two our quiet *tête-à-tête in these sylvan scenes was rudely broken in* upon by similar queries addressed to us in earnest tones, and with pleading eyes.

I remembered my early days at Guy's in the long ago, and how I used to visit Bethlem, and there, safe under the protection of dear Dr. Savage, did hold sweet converse with the fair inhabitants of that modern Babylon. And now again the scenes in which I then took part were recalled to me. But O! the difference. Here we had no protector, not even a keeper was to be seen, only two or three maid-servants dawdling on the doorsteps, and the proprietor and his wife busy dispensing tea, strawberries and ices to all and sundry. What could it mean? We were presently to be enlightened.

Our host and hostess had conceived the idea of amusing their guests by setting them to play at "Hidden Proverbs." Once we were let into the secret, we became as mad as the rest, and, for the remainder of the afternoon, we, too, hunted over lawns, through orchards, in the maze, and across the tennis courts in the vain endeavour to find our other halves: my wife to complete her "it's never too late," and I, with "look" in my hand, and "before you leap," the will-o'-the-wisp which I hoped to grasp on every tree trunk, but which ever evaded my pursuit. "All's well that ends well," but O! shall I ever forget my first impressions of that garden party which I had been looking forward to so long.

T. R. A.

Change of Address.

Graham Poock, B.A. Cantab., L.D.S. Eng., from Guy's Hospital, to 295, Vauxhall Bridge Road, Victoria, S.W.

(The Editor will be very glad to receive a postcard with notes of any change of address.)

Otosclerosis.

CLINICAL LECTURE BY MR. W. M. MOLLISON.

GENTLEMEN, — Diseases of the ear can be divided roughly into two groups, those of the conducting apparatus and those of the perceptive apparatus. The disease we are discussing to-day—Otosclerosis—is one which primarily affects the conducting apparatus, and affects a small and very definite part of that apparatus—namely, the margins of the fenestra ovalis, and the foot plate of the stapes fitting into it.

Normally the foot plate of the stapes is capable of definite excursion in and out in the fenestra ovalis. This excursion is brought about by the sound waves impinging on the tympanic membrane, whose movements are in turn transmitted through the malleus and incus. The movement in and out of the stapes sets up waves which pass to the organ of Corti in the internal ear.

In otosclerosis this movement of the stapes becomes limited, not by a sclerosis, as the name suggests, but by a deposit of spongy bone round the fenestra ovalis. In consequence of this spongy condition of the bone the disease was named by Siebenmann, "Spongy degeneration of the labyrinth capsule."

Many have investigated the disease post-mortem and fully discussed the deposit of bone round the foot plate of the stapes, but, perhaps, the work of Politzer and Bezold may be looked upon as having done most to connect the pathological and clinical features.

In 1885, Bezold investigated post-mortem a case of suspected otosclerosis; he cut microscopical sections through the temporal bone, and found the stapes fixed by a bony mass into the oval window. In 1893, he examined another case and found this same condition of "stapes ankylosis." Both these cases had been subjected to a full clinical examination shortly before death. The second case demonstrates very well the characteristics of the disease.

A woman of 65 was taken into hospital suffering from carcinoma ventriculi. She had heard badly for thirty-eight years, and for the past nine years had got distinctly worse; she had had no giddiness and no tinnitus. Her father and one sister were deaf. Examination of the membranes showed both to be practically normal except for slight dulling in the posterior halves. The hearing tests gave the following:— Conversation speech was heard scarcely at all on the right side, and only at a distance of 2 cm. on the left.

Schwabach's test—bone conduction from the vertex of the skull—showed an increase of nineteen seconds beyond the normal.

Rinné's test—comparison of conduction through air and through bone (the mastoid)—gave a marked negative result, fifteen seconds on the right and thirteen seconds on the left. This test was performed with "a^1" fork. The lower tone limit was raised and the upper tone limit was depressed.

The woman died three weeks later from pneumonia.

Post-mortem, there was a slight amount of recent otitis media, from which the pneumococcus was cultivated, doubtless a terminal infection. The Eustachian tubes free. In the temporal bones, even to the naked eye, the stapes could be seen fixed by spongy-looking bone in the oval window, and in microscopical sections new bone was found extending as high up as the facial canal, down on to the promontory and to the inner aspect of the oval window, the stapes and the margin of the window being fixed together.

With this condition of stapes ankylosis we notice there were present some striking clinical signs—the very high grade of deafness, combined with a greatly lengthened bone conduction; especially is this remarkable when the age, 65, is considered; most persons at 50 have a decidedly shorter duration of bone conduction than at 30. Rinné's test, too, gave a very negative result. By normal individuals the "a^1" fork is heard thirty seconds longer through air than through the mastoid (*i.e.*, Rinné's test is positive), while in this woman it was heard fifteen and thirteen seconds longer when held on the mastoid than when held in front of the ear, on the right and left sides respectively. The membranes were normal and the Eustachian tubes were patent.

For comparison with this case is the following, where only the clinical aspect is known.

C. K. B., a man of 35, came complaining of deafness and tinnitus. Deafness had been noticed for fifteen years more or less; he dated its onset at the time he left school; this deafness had progressed slowly, and showed variations, being less when the man himself was in good physical and mental condition, and more when he was depressed or run down. Tinnitus had been present as a "thumping" noise, but recently had been replaced by a "singing." He had had no pain. He had had "gatherings" once or twice; as far as could be

ascertained these were the results of boils in the meatus. He had been subject to "catarrh" when the skin peeled off his ears. In appearance the man appeared perfectly healthy, and he had recently married. Though never taught, he lip-read fairly well.

On examination, the meatuses were wide and the skin dry and slightly scaly; they were not irritable; the membranes were both almost normal, though perhaps slightly dulled. The nose was quite free, and the nasopharynx absolutely clear. The Eustachian tubes were patent.

Functional examination.—The patient could only hear conversation speech at a distance of 6 c.m. on the right, and at 5 c.m. on the left; the deafness was thus of high degree.

Weber's test.—This test is carried out by placing a fork "A" on the middle line of the head and noticing whether the sound is referred by the patient to either side, and if so to which. When the conducting apparatus of one ear is more affected, the sound of the fork is referred to that side. In this case the sound was not referred to either side.

Schwabach's test showed bone conduction to be lengthened nineteen seconds beyond the normal.

Rinné's test was markedly negative on both sides.

Lower tone limit was much raised; a fork vibrating sixty times per second was not heard at all. Normally one vibrating sixteen times per second is heard distinctly.

The upper tone limit was not fixed, but was certainly much depressed.

Gellé's test was negative. This test is performed as follows:—A tightly-fitting earpiece is connected by a piece of stiff rubber tubing to a rubber bag (a Politzer's bag), so that pressure applied to the bag will compress the air in the meatus, and drive in the membrane; this causes movement of the malleus and incus, and so of the stapes, which fits into the oval window. When the stapes is driven in, the pressure in the inner ear is increased. When in the case of a normal person a tuning fork ("A") is struck, and its stem placed on the rubber tube, the sound is heard in the ear; on compressing the bag the sound dies away or becomes quite faint, and on releasing the pressure it returns once more almost to its previous loudness. If the stapes is fixed, obviously pressure on the bag will not be able to push the foot plate into the oval window, and no change in intensity of the sound will be noticed; this condition is indicated by saying that Gellé's test is negative. In reality, this test is not at all easy to carry out, especially in patients with a high grade of deafness, because the fork, however hardly struck, dies away so quickly that by the time the pressure is released it probably is not heard at all, or only very faintly.

The functional tests in this man were strikingly similar to those in Bezold's patient, and there can be no doubt that the case was one of otosclerosis, or, as it should be called, stapes ankylosis; and doubtless should we see the temporal bone, we should find the stapes fixed firmly in place by a mass of newly-formed bone.

Certain points deserve special note. The patient was a man, and a young man—the disease started when he was about eighteen,—and it is a very usual thing for stapes ankylosis to attack young people; and in this "young" type girls are more often victims than men.

No other members of his family were affected as far as he knew; that is distinctly unusual, for heredity has been found to play a very marked rôle in the causation of the disease. Körner and Hammerschlag found that five families provided forty-three cases of otosclerosis, most striking figures to support the hereditary theory of the causation.

It should be noticed that he read the lips fairly well, though he had not been taught; this aptitude for picking up lip-reading among deaf people is always marked, and whenever it is seen that patients look at one's lips and not one's eyes when talking, a high degree of deafness may be expected. The tinnitus from which he suffered is a frequent symptom of the disease, especially in the earlier stages.

One symptom which this patient did not exhibit should be mentioned as typical of the disease, and that is paracusis Willisii—hearing better in a noise, than when in quiet surroundings.

Unfortunately the *prognosis* is very poor; as we see, the disease may come on in early life and progress to almost complete deafness in a few years; this is not always the case. Sometimes after reaching a certain stage it may remain stationary for years and then once more progress.

Knowing, then, that the prognosis is so bad, diagnosis in early stages is important, because we can then advise patients as to their future life, and can save them from treatments, perhaps unpleasant, and almost certainly useless. While they can still hear they should be urged to learn lip-reading, so that if and when the deafness becomes worse they will be able to understand conversation and be saved from the distress of the absolutely deaf. Further, they

must, if possible, be advised to take up some line of business which does not bring them into personal contact and personal competition, but one which for the most part is carried out by correspondence. The man under consideration had already found out for himself that he was a failure at business where he came into personal contact, and had begun most wisely to look after the correspondence work only.

The best treatment consists in recommending patients to keep themselves in good physical condition; this not only helps to keep the disease in check, but also to ward off the mental depression which tends to assail these patients.

To improve or maintain the general health, a holiday in a climate which is found to suit the individual should be advised; of drugs, those containing phosphorus and strychnine are the best.

Local treatments in *pure* cases of otosclerosis have been up to the present without avail, and when the pathological anatomy is considered no wonder will be felt. Only in those cases where there is some complication, *e.g.*, obvious nasal obstruction, an atrophic rhinitis, or naso-pharyngeal catarrh, will treatment be indicated, and will be directed to correcting any of these local defects.

In early cases diagnosis is not easy, and the disease is apt to be confused with chronic adhesive catarrh of the middle ear, in which disease there is also marked defect of the conducting apparatus: the main points to bear in mind in otosclerosis are the lengthened bone conduction, the negative Rinné, the normal membrane, the open Eustachian tube and the negative Gellé. In the chronic catarrh, normal bone conduction, negative Rinné, the membrane slightly dulled and probably retracted, the Eustachian tube obstructed somewhat, and a positive Gellé.

Papers by Guy's Men.

F. W. Pavy, M.D. Lond., F.R.S., and H. W. Bywaters, D.Sc., Ph.D., F.I.C.: On the Presence of Sugar in Healthy Urine as a Source of the Osazone Reaction.—*British Medical Journal*, 9th July, 1910.

R. J. Pye-Smith, Ch.M., F.R.C.S. Eng.: Principles of Practice in Relation to our Patients.—*British Medical Journal*, 16th July, 1910.

J. H. Ryffel, M.A., M.B., B.C. Camb.: Critical Review: Lactic Acid in Metabolism: Part II.—*The Quarterly Journal of Medicine*, July, 1910.

Lauriston E. Shaw, M.D. Lond., F.R.C.P. Lond.: The True Aim of a United Medical Profession, and the Handicap of the Trade Union Bogey.—*British Medical Journal*, 16th July, 1910.

In Lighter Vein.

SITUATIONS VACANT AND WANTED; ARTICLES FOR SALE, Etc.

Gentlemen seeking perfect positions should try our plates. Best 'screws' attaching to same. How to be happy though fractured. Apply, Willie.

Special Ear-protectors for Sale. Suitable for gentlemen attending anatomy demonstrations by A. R. T. or T. B. L. Owner has no longer need for same. Apply, Surgical Ward Clerk.

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Eminent physiologist seeks engagement as drawing room entertainer. Harmless and amusing. Large stock of homely jokes.

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Wanted. A negative Wassermann reaction. Disbeliever.

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For really good openings in all directions write to Midline Agency, 21, Arbuthnot Lane, W.

Quite! Quite! Quite! private detectives, discrete inquiries conducted in all cases of flea-bites and other assaults. Shadowing carried out with much success. The French Agency, Auscultate, London.

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

His First and Last Biennial Dinner.

SIR,—Little did I think, when I was sitting next to poor Willie Hearnden at the late Biennial Dinner, that he was so soon destined to depart this life. Hearnden seemed cheerful and looked the picture of health that night, when we were busily chatting about our past student days, and when I took up the *Daily Telegraph* on the following Friday and saw the announcement that he had died suddenly on the previous Wednesday, only four days after the Dinner, I could scarcely believe my eyes. There was nothing in Hearnden's appearance, as far as I could see, to indicate that his end was so near, as he was sun-burnt, such as one is wont to see in a country doctor, and apparently, as I have intimated before, looked quite fit. There is one thing I noticed, and that is, although we had such an excellent dinner, he seemed to eat very little. In course of conversation, also, he told me that if he had his time over again he would not work so hard as he had done. I laughingly rejoined that hard work never killed anyone, and he added, "I cannot agree with you there."

This was the first time that I had met Hearnden since we were students together, and, from what I could gather, it was his first attendance at a Biennial Dinner.

W. F. Hearnden was very popular in his year, and was very industrious, being one of the very few men, in those days, who passed the First Fellowship of the College, but he told me that he never took the trouble to go up for the Final. His father was a well-known practitioner in Sutton, and his three brothers all entered the medical profession, all of them qualifying from Guy's. I am sure that all the Guy's men who knew Willie Hearnden in the old student days will feel sorry to hear that such a promising career has been cut short in the prime of life.

There was no family, but many will sympathise with his widow in her sad bereavement.—I am, yours faithfully,

R. J. BRYDEN.

Gravesend,
July 16th, 1910.

Accidents to Medical Men.

DEAR SIR,—In the present issue of the GAZETTE I notice an account of a regrettable accident to an esteemed Guy's man, but am glad to learn that he is making satisfactory progress. Incidents of this kind cannot fail to impress one with the importance of not only making provision against accidents, but also against sickness, which may suddenly and unexpectedly overtake medical men in active practice and in full vigour of health.

The necessity of providing a substitute, and the loss of income during an illness, are often matters of serious importance to the medical man, to say nothing of the resulting worry and anxiety.

I cannot too strongly impress on all young men starting in practice the advantages of insuring against sickness and accidents.

The choice of office in which to insure is a matter requiring careful consideration. There are many offices which undertake sickness and accident insurance; but most of them allow sick pay for a very limited period only. So far as I am aware, no office offers such favourable terms to medical men and dentists as the Medical Sickness Society. This society was started during the Annual Meeting of the British Medical Association, held at Liverpool in 1883. At that meeting one of the speakers said "that no provident society which does not make some provision for cases of prolonged or permanent disablement by sickness will fulfil the requirements of the Medical profession."

The Medical Sickness Society fully meets this requirement. As an example I may mention a case. A member joined the society in 1884; within one year of joining he was attacked by locomotor ataxy, and was totally incapacitated for a period of fifteen years, and received in sick pay the sum of £1,850. Under the rules of the society a member may join for sickness pay of £2 2s. to £4 4s. per week, and this can be further increased if desired, under certain conditions, to £6 6s. or £8 8s. per week.

Should any of your readers be interested in this matter they can obtain full particulars from the secretary of the society, 33, Chancery Lane, London, W.C.

One word more. As under the rules of the Medical Sickness Society sickness pay stops at the age of 65, it is advisable to secure an annuity payable at that age, and so make some provision for that time when the lamp of life begins to burn low.

I trust you will pardon me if I have made use of the accident reported in the GUY'S HOSPITAL GAZETTE, "to point a moral or adorn a tale."—Yours faithfully,

"Lynhurst," ST. CLAIR B. SHADWELL.
Walthamstow, 11th July, 1910.

Murphy's Button.

DEAR SIR,—In your last issue of the GAZETTE I observed the statement that "Mr. Symonds was the first surgeon to use a 'Murphy's Button' in England." This is incorrect; Mr. Arbuthnot Lane being the first surgeon to utilise the button in *Europe* in January, 1894.

See *Lancet*, 1894, vol. i., p. 1006.

C. H. M.

At Dr. Hertz's Demonstrations on Nervous Cases.

1.—A CASE OF PARALYSIS AGITANS SIMULATING DISSEMINATED SCLEROSIS.

THE patient is a woman of 43, who has had a good deal of worry, but no definite illness. About three years ago she began to have a tremor affecting the left hand. This tremor, which was associated with some stiffness, gradually spread to the left leg and to the other hand, and during the last six months it has quite prevented her from doing her work.

When she sits still, with her hands in her lap, there is no obvious tremor. When, however, she lifts her left hand to her face, the tremor is observed. This suggests that it may be an intention tremor, and it is therefore not surprising that she was sent here as a case of *disseminated sclerosis*. Against such a diagnosis are the following facts:—The age of 40 is rather late for the disease to begin. Of the other classical signs, nystagmus is absent; the speech is slow and halting, but not typically scanning. The abdominal reflexes, which are lost very early in disseminated sclerosis, are unaffected in this case. Moreover, before one is justified in diagnosing disseminated sclerosis, one should have some evidence that the lateral columns are affected, whereas, in this case, the knee-jerks are normal, and there is no ankle clonus. (No plantar reflex could be obtained, even after the feet had been placed in hot water, which is the most favourable condition for obtaining the reflex.)

Disseminated sclerosis may therefore be excluded. The tremor is not really an intention tremor; the tendency for it to stop when the hand is resting on the lap is probably due to the support it receives in that position; when the hand hangs freely by her side the tremor at once begins; it can be controlled by an effort, and it is increased by excitement.

The patient's gait is characteristic. She walks with a certain amount of stiffness, with the legs and body slightly flexed, and the arms bent; she has an appearance of falling forward all the time, and a tendency to run—a condition which has been described as "chasing the centre of gravity." A very slight push in front makes the patient take several steps back.

All these features are typical of *paralysis agitans*, though the patient's age—40—is exceptional for that disease; it usually begins well after 50.

From this point of view we may now examine the hands and face. The hands show neither a lower nor an upper neuron lesion, for though there is weakness, there is no atrophy of the muscles; and though there is stiffness, the arm jerks are not increased. The hands are held in the characteristic position seen in paralysis agitans—flexion at the metacarpo-phalangeal joints and adduction of the thumb—which is due simply to stffness, without any other muscle or joint changes. In the face it is noticed that there is a lack of expression, blinking is rare, and very little movement of the face occurs in talking.

Treatment is directed towards relief of the two chief symptoms—tremor and stiffness. For the first: $\frac{1}{200}$ gr. doses of hyoscine hydrobromide in aq. chloroformi t.d.s. may be given. The stiffness will be alleviated by massage and passive movements, especially by passive extension of the elbow, followed by active flexion, and by straightening and separation of the fingers and thumb.

2.—TABES WITH MUSCULAR ATROPHY.

The patient is a woman of 40. She shows a condition of atrophy of the arm, hand and scapular muscles, with very feeble power of movement in them, and these symptoms have developed gradually during the last nine months. There is therefore a lower neuron paralysis, and either the anterior cornual cells or the peripheral nerves are affected. Though there is not at present any weakness in the legs or difficulty in walking, the knee-jerks and tendo Achillis jerks are lost; the plantar reflex is flexor.

There is therefore no evidence of lateral column disease, and the case cannot be one of *amyotrophic lateral sclerosis*. It might be one of the rare cases of pure *progressive muscular atrophy* without any lateral sclerosis, but in that disease it is usually a considerable time, a matter of many years, before the atrophy is as well marked as in this case.

The loss of the knee-jerks, without atrophy of the leg muscles, shows that there is a block in the reflex path upon which muscular tone depends; this is probably from loss of the muscle sense, and suggests a diagnosis of *tabes*. This is confirmed by the condition of the pupils, which fail to react to light, though they still react to accommodation.

In all probability, therefore, the case is one of tabes, in which, as happens in rare cases, the anterior cornual cells have been involved in the same parasyphilitic process which, in ordinary cases, only affects the posterior columns. We

are testing this view by an examination of the cerebro-spinal fluid, which contains lymphocytes in syphilitic and para-syphilitic diseases of the central nervous system, and by the Wassermann reaction.

Nursing News.

Matron's Office.

On July 2nd, Miss Margaret Gardner, who completed her three years' training in December last, and has since been on the Private Nursing Staff, was appointed Second Home Sister.

On June 25th, Nurse L. Turner left the Hospital on completion of her three years' training, to take up her duties on the Private Nursing Staff, and Probationer Kennedy was appointed to succeed her as Head Nurse in Miriam Ward.

On June 29th, Nurse Leach left the Hospital on completion of her three years' training and Probationer Marriott was appointed to succeed her as Head Nurse in Queen Ward.

On June 29th, Nurse Nixon, Head Nurse in Patience and Samaritan Wards, left the Hospital, having completed her three years' training on May 29th.

On June 30th, Nurse F. E. Ward was appointed Head Nurse in John Ward.

On July 4th, Nurse Lustic was transferred to the Isolation Wards, and Probationer R. Miller was appointed to succeed her as Head Nurse in the Theatres.

On July 8th, Nurse E. Foster was appointed Head Nurse in the Surgery.

On July 18th, Nurse C. Ward left the Hospital on completion of her three years' training, to take up her duties on the Private Nursing Staff, and Probationer Owen was appointed to succeed her as Head Nurse in Stephen Ward.

The result of the Probationers' Examination in Surgery, which was held on June 27th, is as follows:—*First Class.* Probationers Achurch, Brereton, de Carteret, Foster, G. Fletcher, Greaves, Hodgkinson, Lay, Lear, Middleton, Paul, Pearson, Probert, Sime, Templeman, and Windley. *Second Class.* Probationers Balkwill, Beardshaw, Beirne, K. Blenkarn, Bourdillon, Brooks, Colston, Dickin, Douglas, H. Edwards, Feeney, Fothergill, Freshney, Garnett, Gooderham, Hewitt, Hirst, Hughes, Hutton, Jagger, Lewin, Mallonek, Mansfield, Masters, Maughan, M. Millar, Mutford, Naylor, Oliver, C. Orchard, O'Rorke, Patterson, Percy, Phillips, A. Prince, Quin, Randles, Rudd, Selby, Servais, Shann, S. A. Simpson, Skou, Spurway, Squire, Sterling, Stevens, Strange, Stretton, Sutherland, Teague, Thomas, Trice, C. A. Ward, Waterman, Weighill, Welby, and Yeoman.

Miss E. G. Graham, Assistant Matron, Royal United Hospital, Bath, has been appointed Matron of the General Hospital, Weston-super-Mare. Since completing her training at Guy's in 1901, Miss Graham has held the posts of Sister at the Dulwich Infirmary, and Sister and Temporary Home Sister at the Children's Hospital, Shadwell.

The following Candidates from the Guy's Institution were successful in passing the recent examination for the certificate of the C.M.B.:—M. E. Dudding, M. I. H. Gidney, R. McC. McMorland, C. M. Stewart, E. C. Strappini.

Out-patients' Tea Fund, Christmas, 1909.

The Secretary of the Committee of the Out-patients' Tea, Christmas, 1909, has forwarded us the following statement of receipts and expenditure:—

BALANCE SHEET.

Receipts.

	£	s.	d.
To Balance brought forward from last account	16	17	4
„ Donations, Collecting Cards, etc.	90	8	4
	£107	5	8

Expenditure.

	£	s.	d.	£	s.	d.
By Cost of Tea, Refreshments, etc.	34	5	0			
„ „ Clothing	11	4	5			
„ „ Toys	13	13	4			
„ Cinematograph Expenses ...	8	8	0			
„ Decoration Expenses	3	12	1			
„ Printing, Stationery, and Postage	2	16	7			
„ Fees to Police, etc.	3	5	6			
				77	4	11
„ Balance available for distribution				30	0	9
				£107	5	8

Audited and found correct,
CHAS. H. WELLS,
Incorporated Accountant.
February 8th, 1910.

It will be seen from the above statement that a balance of £30 is available. £15 of this, we understand, is to be handed on to the Samaritan Fund, which was started the previous year, and has since carried on good work with much success. The other half of the balance is to be carried forward to the fund for the Christmas Tea this year. We congratulate all those workers who have been responsible for the collection and administration of this Fund, and especially on their wise policy of aiding the Samaritan Fund, by which the out-patients benefit throughout the year, and not only at the Christmas season.

Reviews, etc.

Books for review should be addressed to The Editor, Gazette Office, Guy's Hospital, S.E. Their price should in every case be stated.

Difficult Labour. A Guide to its Management for Students and Practitioners. By C. Ernest Herman, M.B. Lond., F.R.C.P., F.R.C.S. New Edition. (Cassell & Co.) Price 12s. 6d.

Chapters on retroversion of the gravid uterus and on puerperal eclampsia are scarcely to be expected in a work on "Difficult Labour," nevertheless, Dr. Herman has been well advised in including them in this the fifth edition of his well-known book. Eclampsia has been included in response to the wishes of some readers of former editions, and retroverted gravid uterus because Dr. Herman has found that much misconception as to the effects and treatment of this condition exists.

In speaking of the effects of treatment in eclampsia, Dr. Herman points out that the average mortality in this disease, when large numbers of cases are taken together, is about 20 per cent. Therefore, "whatever kind of meddling is employed, so long as it is not actively injurious, the chances are four to one in favour of the patient's recovery, and the patient's friends will put her recovery down to the credit of the particular kind of meddling employed. The more fuss the doctor makes the more pleased they will be, and he will be only half-hearted in his fussing if he doubts its utility. Hence the difficulty of estimating the value of treatment in eclampsia." Dr. Herman summarises his views on treatment in this condition by recommending the injection of morphia and atropine in a patient who has had one or more fits, and is insensible but restless; baths when there is coma and pyrexia; and venesection combined with saline infusion in certain cases. He is particularly opposed to the employment of any method of rapid delivery, including Cæsarian section, and concludes his advice:—"Let labour go on naturally. Interfere only if some condition is present which would demand interference in a patient not suffering from eclampsia." On the other hand, the whole question of Cæsarian section in eclampsia was recently discussed by the Obstetrical Section of the Royal Society of Medicine, and it was there stated that Professor Bumm had reduced the mortality of his eclamptic cases at the Charité from 25–30 per cent. to 2–3 per cent. by the routine adoption of rapid delivery, so that the question cannot be regarded as settled.

Difficult labour remains one of the most important subjects demanding the attention of the practitioner, and this book remains a most valuable work for his practical guidance. With its increase in size, it has not lost its charm of language. Dr. Herman speaks with very engaging frankness about any fanciful hypothesis, or any method of treatment of which he does not approve. Thus, he is no believer in pubiotomy, and he describes the operation only to condemn it. "I take the description of it from a paper by Dr. Hastings Tweedy, who has fitted himself to describe the operation by actually performing it," he says.

Finally, the simplicity and directness of Dr. Herman's style make the reading of the book a pleasure instead of, as with too many technical text-books, a torture.

Proceedings of the Royal Society of Medicine. June, 1910. (Longmans, Green, & Co.) Price 7s. 6d. net.

The current number of the "Proceedings," by its thinness, shows the effect which summer has on learned societies generally. Nevertheless, it contains several interesting and useful papers. Chief among these are two papers by Dr. Cammidge on the diagnosis of pancreatic disease by laboratory methods. The first of these is "A Consideration of the Results of the Pancreatic (Cammidge) Reaction in 1,475 Cases." The method of carrying out the reaction has apparently been a good deal elaborated since it was first published, and since small errors in procedure may vitiate the result, the method is given in some detail. Of the 1,475 urines examined, fifty were from normal subjects, and none of these gave a positive result The remainder were cases of acute and chronic pancreatitis, pancreatic cysts, calculi and cancer, and a large miscellaneous section containing cases of many diseased conditions unassociated with the pancreas. Of the latter, practically none gave the reaction. Cases of malignant disease of the pancreas do not give the reaction unless there is some concomitant inflammation, so that, while the reaction "is of value as showing the presence or absence of pancreatitis in a case of persistent jaundice, it does not differentiate between those in which the inflammation is the result of malignant disease and those in which it is of simple origin." With regard to the nature of the pancreatic reaction, Dr. Cammidge remarks that his experiments "point to its being due to the destruction of substances with a glyco-nucleo-proteid content which yields a pentose on hydrolysis, and, since the percentage of pentose in the dry weight of the pancreas is nearly five times as great as in any other organ of the body, and it is more loosely combined and more readily set free than the corresponding sugar in other tissues, the reaction is obtained with very much greater frequency and more constantly in lesions involving active degenerative changes in that organ than in others."

As a supplementary aid to diagnosis in cases of pancreatic disease, Dr. Cammidge lays considerable stress on an examination of the fæces, and that is the subject of the second paper.

In the Therapeutical and Pharmacological Section, Dr. Charles Bolton has a paper on "Some Points in the Treatment of Gastric Ulcer." Dr. Bolton considers that acute gastric ulcer of normal or delayed healing is to be treated by medical means, except those cases which perforate, and perhaps a few in which dangerous hæmorrhage occurs; these latter are to be handed over to the

surgeon. Of the cases of true chronic ulcer, probably more than half, he thinks, should be treated surgically, but a three months' medical treatment is to be tried first, followed by careful dieting, when, if further symptoms occur (pain, vomiting, hæmatemesis), the ulcer is probably incurable by medical means. All cases of pyloric obstruction, hour-glass stomach, perigastric adhesions and perforation are to be at once treated surgically. In the same section, Dr. Langdon Brown has a paper entitled "A Criticism of some Principles in the Treatment of Chronic Nephritis."

The Epidemiological Section contains the discussion on Dr. Niven's paper on "Summer Diarrhœa and Enteric Fever."

To the Obstetrical Section, Mr. Frederick McCann contributes a paper on "Cæsarian Section in the Treatment of Eclampsia Gravidarum, with Notes of a Successful Case," which gave rise to a good deal of discussion.

There are two contributions by Guy's men to the Section for the Study of Disease in Children. Dr. E. Bellingham Smith showed a case of "Amaurotic Family Idiocy," and Mr. H. B. Carlyll a specimen of an "Enormous Sarcomatous Tumour in a Child aged 2 Years."

It is announced that the next number of the "Proceedings" will not be published until early in October, when the discussion on Vaccine Treatment will be issued as a special supplement to the ordinary volume.

We have received a specimen copy of *Walker's Medical Loose-Leaf Pocket Book*, which is one of the most useful pocket-books we have seen. It consists of a number of separate sheets held together on a file, and printed according to the various possible needs of a medical man. The sheets when filled can be removed from the book and kept in transfer cases supplied by the firm, thus enabling a permanent record of cases, temperature charts, visits, etc., to be kept, while only a moderate-sized book need be carried about. This is an entirely novel idea, and one which should prove of the utmost utility, providing, as it does, note-book facilities and permanent records at the same time. The book is nicely got up, and by altering the sheets contained in it, can be suited to the individual owner's need. The prices are extremely reasonable, and we can recommend the book as likely to be of the utmost service to students and practitioners alike. Books, refills and transfer cases are to be obtained from John Walker & Co., Ltd., Farringdon House, Warwick Lane, E.C.

Literary Intelligence.

Messrs. J. & A. CHURCHILL are about to publish four books in new editions:—

Serum Therapy, Bacterial Therapeutics and Vaccines. By R. Tanner Hewlett, Professor of General Pathology in King's College, London.

The Microscopical Examination of Foods and Drugs in Entire, Crushed and Powdered States. By H. G. Greenish, Professor of Pharmaceutics at the Pharmaceutical Society of Great Britain.

A Manual of Dental Metallurgy. By Ernest A. Smith, late Demonstrator in Metallurgy, Royal School of Mines.

Hernia, its Cause and Treatment. By R. W. Murray, Surgeon, David Lewis Northern Hospital.

Preparations Received.

Diabetic Bread.

We have received a sample tin of the BRUSSON JEUNE Gluten Bread for use in Diabetes and other conditions in which starch is inadmissible. As shown by the Iodine test, this bread is quite free from starch, and when given to diabetic patients, it was pronounced to be extremely palatable, a most important fact, since the majority of similar preparations are decidedly the reverse. The bread is in the form of rolls, and is sent out in sealed boxes of 15 and 60 rolls respectively, which enables a large supply to be kept without risk of deterioration. The bread conforms to the three essentials in preparations of this nature; freedom from starch, a pleasant taste, and high nutritive value, and so can be safely advised as an addition to the usually somewhat monotonous diabetic diet. The bread, and the other preparations of the Brusson Jeune Company, can be obtained from the London Office, Bedford Chambers, Covent Garden, W.C.

Pass List.

University of Cambridge.

THIRD EXAMINATION FOR MEDICAL AND SURGICAL DEGREES.

PART I.—PHARMACOLOGY AND GENERAL PATHOLOGY.

H. W. Barber, Clare	W. C. D. Maile, Pemb.
H. Lee, John	F. D. Saner, Christ's
A. J. McNair, Emm.	A. M. Zamora, Christ's

University of Oxford.

SECOND EXAMINATION FOR M.B. AND B.CH.

MEDICINE, SURGERY AND MIDWIFERY.

G. H. Hunt, Christ Church.

PATHOLOGY.

T. B. Heaton, Christ Church.

FORENSIC MEDICINE AND HYGIENE.

E. P. Poulton, Balliol.

Sport.

United Hospitals Sports.

Owing to the pressure of examinations, the secretaries have been obliged to withhold their account of the above meeting, which was held on June 24th.

For the second year in succession Guy's had to face a disappointment, for after appearing like winning the shield at the earlier part of the afternoon we were eventually defeated by London Hospital by eight points.

It is unfortunate that the hospital possesses no good men at the middle distances, and it is usually at such distances that no points are gained. We should like to congratulate all the members of the Guy's team, more especially those who were successful, on their running and keenness. In conclusion, let us say how pleased we were to see so many of the Staff present, for it is a source of encouragement to the fellows to know that their seniors are taking an interest in their doings.

A list of the Guy's successes is appended:—

100 YARDS.—H. W. Evans, 1st.

220 YARDS.—H. W. Evans, 2nd.

440 YARDS.—E. S. Bowes, 3rd.

MILE.—W. K. Fry, 2nd.

THREE MILES.—J. A. Barrow-Clough, 1st; A. P. L. Johnson, 2nd.

HURDLES.—H. F. Renton, 2nd.

SHOT.—A. L. Stokes, 1st.

HAMMER.—W. G. Tucker, 2nd.

Guy's won the Tug-of-War by 2 pulls to 0.

Cricket.

GUY'S v. MIDDLESEX.

INTER-HOSPITAL CUP TIE. FINAL ROUND.

This two-day match was played at Winchmore Hill on Thursday and Friday, 14th and 15th of July. Guy's played the same team that beat London in the semi-final. Montgomery again won the toss, as in previous cup ties, and decided to bat first on a wicket which had not completely recovered from the recent rains. Guy's made a disastrous start, the first wicket falling at 5, and the fifth wicket at 47. Of the first batsmen, Munden was the only one to meet with any success. Digby and A. F. Rook then became associated, and made a fine stand, adding 76 runs for the sixth wicket. Digby's dismissal soon followed that of Rook, and then Kahlenberg and Hunôt made a useful stand, the former hitting in a refreshing manner. Hancock arrived just in time to have his innings, he having been detained by examiners at the London University. He was not destined to make many runs, as he was run out in rather an unlucky manner, Kennedy hitting the ball hard back to the bowler, who deflected it on to the wicket. The Guy's first innings thus closed for 198 runs, a useful total considering the early collapse.

Middlesex then went in to bat against the bowling of Kahlenberg and Digby. Both bowled well, but on Hancock going on to bowl, with the score at four wickets for 50, he put up a remarkable performance, taking five wickets for 3 runs. He varied his pace and break with great cleverness, and, backed up by good fielding, his bowling was unplayable.

Guy's started their second innings with a commanding lead of 107 runs. This advantage, however, was not taken full advantage of, as the batting was rather lifeless, except for that of Veale, Hancock and H. C. Rook, the last-named especially playing a good innings. The innings closed for 137 runs, and Middlesex went in requiring 247 runs for victory. They had twenty minutes' batting on Thursday evening, losing one wicket for 10 runs. Next morning, with five wickets down for 50, it appeared as if Guy's had an easy victory in store for them. Laurence and Clarke, however, raised the score to 106 before the latter was bowled for a briskly-played innings of 35. Laurence continued to withstand the bowling, batting very patiently, and showing splendid defence. He found steady partners in Hardy and Alexander, 40 runs being added for the eighth wicket, and 60 for the ninth, which fell with Middlesex wanting 36 runs for victory. The last wicket fell 10 runs later, leaving Guy's the winners of the Cup by the narrow margin of 15 runs. The steadiness of the Guy's bowling will be understood when it is stated that Middlesex took just over five hours to make 231 runs. Laurence deserves the greatest praise for his splendid innings. He was at the wickets for about four hours without giving a chance, and he came very near to winning the match for his side. The match was played before an enthusiastic but very impartial crowd of Middlesex men, and one Guy's man.

GUY'S.

1st Innings.

R. Montgomery, b Rackham	2
M. M. Munden, c Symons, b Eggar	25
R. M. Veale, b Rackham	6
H. C. Rook, b Rackham	8
A. H. Birks, b Eggar	0
W. E. S. Digby, b Proctor	41
A. F. Rook, c List, b Proctor	43
F. C. Hunôt, c Masefield, b Alexander	21
F. Kahlenberg, c List, b Eggar	36
A. C. Hancock, run out	5
R. S. Kennedy, not out	1
Extras	10
Total	198

2nd Innings.

M. M. Munden, b Alexander	10
A. C. Hancock, b Proctor	27
R. M. Veale, c and b Proctor	35
A. H. Birks, c Symons, b Alexander	1
H. C. Rook, not out	38
W. E. S. Digby, c Montgomery, b Proctor	1
A. F. Rook, b Laurence	2
R. Montgomery, b Laurence	2
F. C. Hunôt, b Rackham	10
F. Kahlenberg, c List, b Eggar	0
R. S. Kennedy, b Eggar	0
Extras	11
Total	137

MIDDLESEX.

1st Innings.

G. Laurence, b Digby	21
P. J. Montgomery, b Digby	8
T. L. Hardy, b Kahlenberg	4
R. W. List, c Munden, b Digby	10
P. W. Symons, c Montgomery, b Hancock	20
R. C. Clarke, b Kahlenberg	0
W. H. Eggar, c H. C. Rook, b Hancock	5
C. E. Proctor, b Hancock	0
H. G. Alexander, c A. F. Rook, b Hancock	1
A. L. Rackham, not out	7
W. G. Macefield, b Hancock	3
Extras	10
Total	89

2nd Innings.

W. H. Eggar, b Kahlenberg	0
W. G. Macefield, c H. C. Rook, b Hancock	13
A. L. Rackham, b Kahlenberg	9
P. J. Montgomery, b Digby	6
G. Laurence, not out	107
P. W. Symons, b Hancock	1
R. C. Clarke, b Digby	35
R. W. List, c Digby, b Hancock	5
T. L. Hardy, b Montgomery	17
H. G. Alexander, b Digby	19
C. E. Proctor, b Kahlenberg	3
Extras	16
Total	231

W. C. HANCOCK'S XI. v. W. P. VICARY'S XI.

A high class of cricket was attained at intervals in the excellent game which took place at Honor Oak Park on Saturday, July 9th, between a team nominally representing the Staff, but in reality a scratch team captained by Hancock, and a team composed of present students, of which a good proportion were mainstays of the 1st XI. Time curtailed the game, the score being 199 for seven, and 102 for six, the ultimate result being variously stated by members of the opposing factions.

Matches of this kind are very interesting, and doubtless edifying, as they stimulate a healthy rivalry, and we hope that the two captains, Messrs. Hancock and Vicary, will have set a precedent which will be followed by the other sections of athletics.

W. C. HANCOCK'S XI.

Dr. Morres, c Gibb, b Harkness	2
Arnold, c Gibb, b Harkness	21
Bond, c Vicary, b Hunôt	22
Harris, c Digby, b Harkness	47
A. C. Hancock, b Harkness	63
Sheppard, c Hind, b Poyser	15
Scott, not out	10
Burks, c & b Andrews	12
Extras	7
Total (7 wickets)	199

Buckland, W. C. Hancock, and King did not bat.

W. P. VICARY'S XI.

G. W. Andrews, c Bond, b Buckland	28
H. C. Rook, b Harris	9
A. H. Harkness, c Arnold, b Harris	5
C. E. Rice, not out	12
Williams, b Hancock	14
W. E. S. Digby, b Sheppard	4
F. C. Hunôt, b Morres	13
Extras	17
Total (6 wickets)	102

Poyser, W. P. Vicary, Gibb, and G. R. Hind did not bat.

Umpires: Messrs. Pelling and Croucher.

Water Polo.

GUY'S v. BART'S.—FINAL.

This resulted in a win for Guy's by 7 goals to nil. The members of the team are to be congratulated on their excellent display. The forwards shot well, York-Moore goaling three, Glover two, and Moberly two, being well supplied with passes from the backs. Smyth's defence in goal was impregnable. Team:—

GUY'S.—Smyth (goal); Clark, Rice (backs); Pern (half-back); Glover, York-Moore, Moberly (forwards).

Appointments.

Civil.

BALL, J. BRAMLEY, L.D.S., R.C.S. Eng., has been appointed Visiting Dental Surgeon to the Royal Naval College, Greenwich, S.E.

DOUBLEDAY, F. N., L.D.S., R.C.S. Eng., has been appointed Dental Surgeon to Messrs. Pascall's Factories.

MOISER, L. H., M.B. Lond., has been appointed Medical Officer of Health for the Crediton (Devon) Rural District.

Births.

MURIEL.—On July 10th, at 109, Scatch Street, Whitehaven, the wife of G. Bertram Muriel, B.A., M.B., B.C. Cantab., M.R.C.S. Eng., L.R.C.P. Lond., of a son.

WATSON.—On July 7th, at the Central Nursing Home, Aberdeen, the wife of Cecil F. Watson, M.R.C.S., L.R.C.P., Zunguru, Northern Nigeria, of a son.

Death.

HEARNDEN.—On July 6th, suddenly, at the "Shrubbery," Mulgrave Road, Sutton, Surrey, William Frank Hearnden, M.R.C.S. Eng., and L.S.A., in his 54th year.

Ed.—A. N. C.

GUY'S HOSPITAL GAZETTE.

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Passim.

THE Wills Library will be open during August this year. The Dental Conservation Room will be closed from to-day until August 29th.

AT the last meeting of the Council of the Royal College of Surgeons Mr. R. Clement Lucas was elected a member of the Executive Committee of the Imperial Cancer Research Fund.

MR. H. C. Lucey has been appointed Ophthalmic House Surgeon, commencing duty on August 1st.

ABOUT a hundred members of the British Medical Association were received at the hospital on Thursday, July 28th, and were shown over the wards and the special departments. A number of medical and surgical and selected X-ray cases were also shown to the visitors, and tea was afterwards provided in the Court Room.

A MEETING of the Medical Branch of the Navy League was held at the Imperial Institute during the Annual Meeting of the British Medical Association. It will be remembered that the branch was originally founded in January of this year, and officers and committee were appointed for the time being. At the meeting held on July 29th, Sir Douglas Powell occupied the chair. Dr. Maurice Craig, who has been acting as Honorary Secretary to the branch, was re-elected to that position, and Dr. Smith was re-elected Hon. Treasurer. The Provisional Committee, which includes the names of Sir Alfred Fripp and Dr. Fawcett, was also re-elected, with power to add to its number. The Treasurer announced that fifty-nine fellows and members had already joined. Fellows subscribe a guinea or more annually, and members five shillings. It is desired to enrol new members, and any of our readers who are in sympathy with the aims of the League, should communicate with Dr. Maurice Craig, 54, Welbeck Street, W., who will supply further information. The aim of the medical branch of the League is to make use of the great influence possessed by members of the profession all over the country in the promotion of a strong and efficient Navy. It is frequently urged, in objection to the expenditure on the Navy, that the money were better spent on social reform, but it is surely obvious that no amount of social reform is of any value unless there is at the same time social security from foreign invasion, and unfortunately, under our existing "civilisation," such social security is very expensive. We wish all success to the new branch of the League, and hope that it may do good work, and succeed in steering clear of party politics.

A MINOR improvement which has recently been effected in the hospital and deserves mention is the rejuvenation of the bust of Sir Astley Cooper, which has long stood in the Medical Building. Sir Astley has been very much improved in appearance by the thorough

scrubbing which he has undergone, and he has been removed from the dark situation where he formerly stood into a much more conspicuous position just inside the entrance to the Medical Buildings, where the list of cab fares from the hospital to various parts of London—now rendered unnecessary by the coming of the taxi-cab—used to hang.

The Annual Meetings of the British Medical Association held this year in London should have called the attention of all newly-qualified men to the great importance of the work of the Association. Moreover, its importance is likely to grow. During the coming years very profound changes in the administration of the Poor Law may be expected, and these changes will affect not only the Poor Law Medical Service, but very probably also the whole body of general practitioners. The medical inspection of school children is a matter already profoundly affecting the general practitioner. In fact, the medical man is directly concerned in nearly all great measures of social reform which are ever proposed. The British Medical Association keeps a watchful eye on all such proposed legislation in order to take care that the status of the profession is not adversely affected by it. The British Medical Association is the only organisation of any importance which thus looks after the interests of the general practitioner. The General Medical Council and the various Colleges of Physicians and Surgeons have long ago shown themselves either unwilling or incapable of doing this work. Does anyone complain that it savours of trades' unionism? If so, we would refer him to Dr. Lauriston Shaw's very excellent Presidential Address to the Metropolitan Counties Branch, which was published in *The British Medical Journal* of July 16th, under the title "The True Aim of a United Medical Profession and the Handicap of the Trade Union Bogey."

"The true professional aim," says Dr. Shaw, "is threefold: first, to seek out the causes, the methods of prevention, and the means of cure of man's physical infirmities; secondly, to disseminate this knowledge amongst all branches of the profession; and thirdly, to ensure that every possible advantage of professional knowledge shall be available for all those who could be benefited by it," and he then points out some of the directions in which united as opposed to individual effort may be expected to be of special value in the attainment of these three aims. But the chief handicap to united action is the "Trade Union Bogey," which he therefore has first to demolish. Trade Unionism is a handicap, because it is scornfully regarded as an opprobrious label by one section of the profession, and proudly and rather extravagantly used as a battle-cry by another section. Therefore Dr. Shaw says:

> I would make . . . . a double appeal. To the enthusiasts on one side I would urge that they commend to our notice such schemes of organisation and co-ordination as they may have at heart, not on account of any analogy there may be to what seem to them the best features of trade unionism, but solely on the ground of their actual advantages to the public and the profession. Whilst to the enthusiasts on the other side I would urge that they should recognise that, however detrimental to the true interests of the community some features of trade unionism may appear to them to be, there are other features that are common to trade unionism and to all other schemes of united effort, and are indeed essential to all progress, and that to rule these out because in some hands they may have been used improperly is not only to handicap but to paralyse all advance.

We have received from the British Fire Prevention Committee a copy of their report on fire tests with flannelette and other textile materials. The dangerous inflammability of ordinary flannelette should by this time be common knowledge, but it is still responsible for many deaths annually, and any measures for the reduction of this terrible mortality will command the public sympathy. The Committee have devised a simple standard test for such textiles as flannelette, and they suggest that all materials not complying with the test should be required by law to be marked with the words "Burns Rapidly," while materials which were found to be to standard should be marked "Non-flaming." They also suggest that traders selling materials or ready-made garments not properly marked, or selling as "non-flaming" a material not complying with the tests, should be liable to prosecution, and that parents and guardians should be made specifically responsible for death or injury from fire to children under the age of twelve wearing union or flannelette material that is marked "Burns Rapidly."

In another part of this issue will be found a series of Pass Lists, which form a very pleasing termination and summary of the work of the Session. In particular we should like to call attention to the excellent results obtained in the Chemistry Examinations of the University of London, and to the mark of distinction in Inorganic Chemistry in the Preliminary Scientific obtained by Mr. W. E. Tanner.

Our new President was the victim of a paragraph in a recent number of our bright little contemporary, *Punch*. On the "Charivaria" page:—"Mr. Cosmo Bonsor has been appointed President of Guy's Hospital, and his friends will watch his future with interest. His predecessor in office has become King of England."

Secondary Parotitis.

By Mr. W. A. MAGGS.

Reprinted from *British Medical Journal*.

Henry T., aged 40, attended at the Dental Department on December 9th, 1909, complaining of pain and swelling of the face, and difficulty in opening the mouth.

The roots of the left second lower molar were found to be bathed in pus—an attempt at extraction had been made a week previously—and on the same side swelling of the floor of the mouth, some ulceration of the inner surface of the cheek, and sloughing at the orifice of Steno's duct. The left parotid and submaxillary salivary glands were enlarged and tender. The tongue was thickly coated with white fur, and the breath very fetid.

The temperature and pulse being high, and the general appearance and condition of the patient unsatisfactory, I removed, without anæsthetic, the roots of the broken-down tooth, and ordered a mouth wash of formaldehyde (1 in 1000) to be used every four hours, and hot boric acid fomentations outside the cheek. A mixture consisting of quinine sulphate, gr. ij, dilute nitric acid, ♏ ij, magnesium sulphate, gr. xv, and water, ʒj, was ordered to be taken three times daily.

At the end of a week the patient returned apparently in normal health. The mouth and tongue were clean, the swelling of the cheek and floor of the mouth had subsided, and there was absence of ulceration.

He brought with him a mass of friable substance, about the size and shape of an almond, which he said had come away spontaneously from the anterior part of the floor of the mouth. The mass, consisting of soft salivary calculus, had presumably been extruded from Wharton's duct, and the specimen has been placed in Guy's Museum.

Secondary parotitis is well recognized as a result of abdominal lesions, especially after laparotomy, and is generally regarded as being due to an ascending infection from within the mouth. The focus of infection in this case was a tooth, and the inflammation of the salivary glands was evidently due to oral sepsis combined with stasis, the patient for some days previously being unable to use the left side of his jaws owing, first, to the condition of the broken and jagged tooth, and later to the swelling of the parotid gland. The chief interest in the case is its rarity, and the rapid recovery of the patient in response to treatment.

Oral sepsis being of common occurrence, it seems remarkable that parotitis due to infection from the teeth is not more frequently seen. I can recall one similar case, and it may be that others have been overlooked owing to the great swelling of the cheek which so often accompanies suppuration within the mouth.

Appointments.

Civil.

Cole, Percival P. Cole, M.B., B.Ch., F.R.C.S. Eng., L.D.S. Eng., has been appointed Deputy Anæsthetist to the National Dental Hospital, W.

Collins, M. Abdy, M.D., B.S. Lond., M.R.C.S., L.R.C.P. Lond., has been appointed by the London County Council Superintendent of the Epileptic Colony, Epsom.

Dunn, L. A., M.S. Lond., F.R.C.S. Eng., has been appointed a Member of the Medical Examining Board at the Admiralty.

Plumptre, C. M., M.R.C.S. Eng., L.R.C.P. Lond., has been appointed Resident Medical Officer of the Camberwell Parish Infirmary.

Strange, E. W., M.D. Lond., has been appointed Honorary Anæsthetist to the Wolverhampton and Staffordshire General Hospital.

Wilberforce-Smith, D., M.B., B.S. Lond., M.R.C.S. Eng., L.R.C.P., has been appointed Assistant Registrar to the Samaritan Free Hospital for Women, Marylebone, W.

Naval and Military.

Surgeon Guy L. Buckeridge, R.N., has been posted to the *Astræa*.

Captain F. A. Barker, M.B., I.M.S., has been appointed Second Medical Officer and Civil Surgeon, Port Blair (Indian Jail Department).

Captain P. K. Tarapore, I.M.S., is appointed to officiate as Superintendent of the Mandalay Central Jail, in place of Captain A. W. Greig, I.M.S., proceeding on leave.

British Medical Association.

Annual Meeting.

IT is fifteen years since an annual meeting of the British Medical Association was held in London, and considerable changes in the fortunes of the Association, as well as in the medical world of London generally, have taken place in the interval. The past fifteen years have also been a critical period in the history of the Medical Schools of London, as it is during that time that the competition of provincial Universities has become acutely felt, and has resulted in the decline in the number of London students. One great advantage as a centre of medical education, however, London must always possess, and that is the exceptionally large field for clinical study provided by its huge population, such a large proportion of whom are of the hospital class. As a centre for post-graduate study, at any rate, London must always hold a pre-eminent place in this country. Unfortunately, there is a characteristically English lack of organisation of this clinical material, and lack of co-ordination between the different institutions, so that London may well be described as "a more or less fortuitous concourse of educational atoms."

Such a meeting as this of the British Medical Association serves to show how great the clinical resources of London really are, and how much can be done by co-operation between its various hospitals, general and special. All the chief hospitals set aside one or more days for the visit of members of the Association, and the exhibition of cases of interest.

We may indicate here the part played by Guy's men in the work of the annual meeting as a whole, and of the various sections, twenty-one in number, in which the scientific work of the meeting is done. First and foremost, we must mention the names of Dr. Lauriston Shaw and Dr. E. W. Goodall, who, as two of the three honorary secretaries, must have had an extremely busy time. All who know their organising ability will readily understand with what success they carried out their multifarious, and no doubt often trying, duties.

The following Guy's men served on committees appointed to carry out the various arrangements for the meeting:—Colonial Reception Committee: Dr. G. Newton Pitt and Mr. Charters Symonds; Excursions Committee: Dr. H. C. Cameron, Mr. W. A. Maggs, Mr. R. Capes and Mr. Kenneth Goadby; Executive Committee: Dr. Maurice Craig, Dr. Lauriston Shaw and Mr. H. R. Ker; Finance Committee: Dr. J. F. Goodhart and Dr. Hetley; Foreign Reception Committee: Mr. Arbuthnot Lane, Sir Shirley Murphy and Prof. Starling; Local Entertainment and Sport Committee: Mr. G. Rowell and Dr. St. Clair B. Shadwell; Medical Museum Committee: Dr. H. S. French, Mr. W. Sampson Handley, Mr. H. R. Ker, and Dr. F. G. Swayne; Reception Committee: Sir Alfred Fripp, Dr. Hale White, and Mr. A. H. Tubby; Club Accommodation Sub-Committee: Dr. Maurice Craig (Chairman).

The following indicates some of the work done, and the part taken by Guy's men, in the different sections.

Anæsthetics.—Mr. George Rowell was one of the Vice-Presidents. The principal subjects discussed by the section were the "Open" System of Ether Administration, the Prevention and Treatment of Surgical Shock during Inhalation Anæsthesia, and the Present Position and Limitations of Spinal Analgesia.

Bacteriology.—Dr. J. W. H. Eyre was one of the Vice-Presidents. The most important business of this section was a joint discussion with the Pathological Section on Complement-Deviation Methods in Diagnosis, which was to have been opened by Professor Wassermann, who, however, was unfortunately prevented from attending.

Dermatology.—Dr. Norman Meachen was one of the Hon. Secretaries.

Diseases of Children.—Mr. F. J. Steward was one of the Vice-Presidents. The section discussed the Diagnosis and Treatment of Infections of the Urinary Tract by the *Bacillus Coli*, and a number of papers on the medical and surgical diseases of children were read.

Medical Sociology.—Dr. F. E. Fremantle opened a discussion on the Social Aspects of the Falling Birth-Rate.

Medicine:—Dr. Herbert French was one of the Hon. Secs. of this section. In a discussion on the Pathology, Prophylaxis, and Treatment of Acidosis, opened by Professor Edsall of Philadelphia, Drs. Spriggs, Pembrey, Beddard, and Ryffel, among others, took part.

An interesting discussion on Chronic Constipation was opened by Dr. Goodhart, and continued by Drs. Hale White and Hertz, and Mr. Arbuthnot Lane, and others. In speaking of treatment, Dr. Goodhart said that much was to be gained by common-sense physiology, summarised as follows:—"The obsession of the urgency of a daily stool to be attacked; so also that other, that blocks readily occur; so also a third, that the colon is a poison bag. Treat bad

habits, irregularity of meals, too little food, the dietetic fad, the curse of pill-hunger. Instil the need of patience and perseverance; leave the bowels alone, by thought and deed, to work out their own salvation."

Among the papers read in this section was one by Dr. A. C. Jordan, on "The Roentgen-Ray Appearances of Thoracic Aneurysm."

Odontology.—Mr. E. B. Dowsett was one of the Hon. Secs. of this section. In a discussion on the Prevention of Dental Caries, viewed from various aspects, Mr. Kenneth W. Goadby considered the effect of variations in the buccal secretions and the part played by bacteria normally present, and Mr. J. H. Badcock opened the discussion on the need for the correction of malposition of the teeth. Mr. Maggs also took part in the discussion.

Ophthalmology.—Mr. Charles Higgens was the president of this section. In his opening address, Mr. Higgens sketched the advances that have been made during his forty years' experience. In the treatment of some eye diseases, notably trachoma, glaucoma, and uveal inflammation, no real advance had been made during that time, although much of interest as regards their pathology had been discovered. He also referred to the great increase in the number of ophthalmic surgeons, who, in his early days, made but a handful, and now were to be counted by hundreds. He hoped that competition would not tend to demoralise them, but that they would always strive after a high ideal.

In a discussion on the Future of Ocular Therapeutics, Dr. Eyre opened the discussion from the side of bacteriology, and emphasised the value of vaccine-therapy in ophthalmic cases when properly used, and where a specific diagnosis had been made. One speaker referred to the usefulness of tuberculin in tubercle of the conjunctiva, and this was confirmed by Mr. A. W. Ormond, who cited his experience of four cases of grave tuberculous periostitis.

Pathology.—Dr. A. E. Boycott was one of the Hon. Secs. Among the papers read were the following:—"Chloroform Necrosis of the Liver," by G. W. Goodhart, M.B.; "The Blood in Malignant Disease," by R. A. Chisolm, M.B.; "Alterations in the Size of Red Blood Corpuscles," by C. Price-Jones, M.B.; "Experiments on Soap Anæmia," by A. E. Boycott, M.D.

Pharmacology and Therapeutics.—Dr. A. F. Hertz was one of the Hon. Secs. One of the most interesting discussions in this section was that on Treatment with Lactic Acid Organisms.

Physiology.—In a discussion on the Food Requirements of Man for Sustenance and Work, opened by Lieut.-Colonel Melville, R.A.M.C., Dr. Pembrey took part. A demonstration on the Production of Cheyne-Stokes Breathing was given by Dr. C. G. Douglas.

Psychological Medicine and Neurology.—Dr. G. H. Savage opened a discussion on Marriage and Insanity. As absolute bars to matrimony he mentioned: Insanity with definite delusions or hallucinations; secondly, persons with a history of marked periodical mental disturbances, particularly occurring at the period of adolescence; thirdly, epilepsy with mental disorder—in fact, he doubted whether any person who had had epileptic attacks ought to marry.

Radiology and Medical Electricity.—Among the papers read was one on "Types of Phthisis from the Radiographer's Point of View," by Dr. A. C. Jordan.

State Medicine.—Discussions were held on the Relation of Poor Law Reform to Public Health Administration; the Etiology and Prevention of Summer Diarrhœa; Town Planning in Relation to Public Health; the Provision of Medical Treatment by Local Educational Authorities; the Administrative Control of Ophthalmia Neonatorum, and on the Reform of Death Certification. Dr. F. E. Fremantle read a paper on "The Influence of Part-time Medical Officers of Health on Public Health."

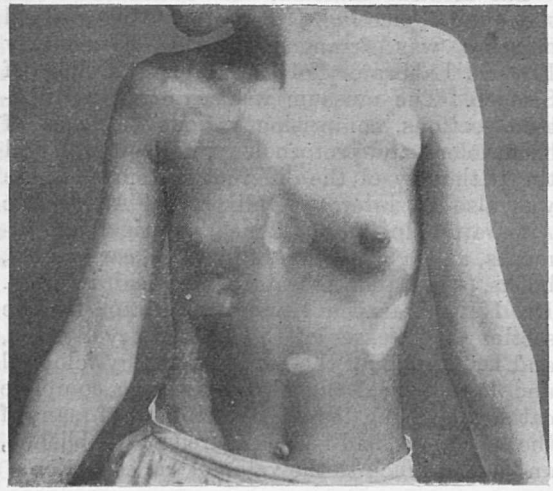
Surgery.—One of the meetings of this section was occupied by a discussion on the "Principles which should govern the Operative Treatment of Simple Fractures," opened by Mr. Arbuthnot Lane. Professor Lucas-Championnière, while expressing admiration for Mr. Lane's work, thought that the method was not one for adoption by every practitioner. Messrs. Morton, Shenton, and Fagge also took part in the discussion.

The Medical Museum.—In connection with the annual meeting, a comprehensive medical museum was arranged in the Elementary Physics Laboratory of the Imperial College of Science. The museum was arranged in nineteen sections, comprising various branches of bacteriology and protozoology, radiography, and the pathology of the different systems. There was also an interesting display of Anæsthetic Apparatus, including some historical instruments, and a collection of pictures, caricatures, books, and other objects of medical interest. Dr. Hertz was the Honorary Curator for the section for diseases of the Alimentary System, and Dr. Ryffel for the section for Physiological and Pathological Chemistry. A very complete catalogue, giving detailed descriptions of many of the specimens, had been prepared and published, and added much to the value of the collection.

A Case of Leucoderma.

H.D., æt. 13 years and 10 months, born at Walthamstow, has had no illness with the exception of measles and whooping-cough. She came to reside at Whitstable-on-Sea about three years ago, soon after which time a

large white spot was noticed on her forehead, which was the more conspicuous owing to her skin being brown, she being in the habit of spending a great portion of her



time on the beach exposed to the sun. She is a very bright and intelligent girl, and has nothing to note, with the exception of the bronzing of her skin as shown in the photos, and some rigidity of both patellæ, and some thickening of the ligamentum patellæ on both sides. Menstruation commenced on June 1st, since which date, up to July 25th, it has recurred twice. Her mother says she has grown rapidly since her change of residence. Her father has suffered from rheumatoid arthritis for years, and had to give up his work; her mother has black hair and a rather dark complexion, and enjoys good health.

Change of Address.

Captain F. A. Barker, M.B., B.C. Cantab., L.R.C.P. Lond., M.R.C.S., from Trichinopoly, Madras Presidency, to Port Blair, Andaman Islands.

C. H. Bradnam, L.D.S., R.C.S. Eng., from Guy's Hospital, to 20, St. Peter's Green, Bedford.

Percival P. Cole, M.B., B.Ch. Birmingham, F.R.C.S. Eng., from University of Birmingham, to 95, Ridgmount Gardens, Gower Street, W.C.

M. Abdy Collins, M.D., B.S. Lond., from Bexley Asylum, Kent, to the Epileptic Colony (London County Council), Epsom, Surrey.

A. A. Greenwood, M.B., B.S. Lond., M.R.C.S. Eng., L.R.C.P., from Guy's Hospital, to 55, Crouch Hall Road, Crouch End, N.

A. Norman Leeming, M.B., B.S. Lond., from Werneth House, Station Road, Old Colwyn, to "Cilgwyn," Wynn Avenue, Old Colwyn, North Wales.

A. L. Paliologus, L.R.C.P., L.R.C.S. Edin., from Beckenham, Kent, to Royal Colonial Institute, Northunberland Avenue, W.C.

H. B. Rygate, F.R.C.S. Eng., from Westerfield Hall, Ipswich, to Sizewell, Leiston, Suffolk.

D. W. Samways, M.A., M.D. Cantab., D.Sc. Lond., from Mentone, France, to Knowle, Clyst St. George, Topsham, Devon.

Miss Traill, from Royal Surrey County Hospital, Guildford, to Knole Hill Park, Cobham, Surrey.

F. J. Wheeler, L.R.C.P. Lond., M.R.C.S. Eng., from 31, Church Street, Southport, to 95, Cambridge Road, Southport, Lancashire.

(The Editor will be very glad to receive a postcard with notes of any change of address.)

PERIODICALS RECEIVED.—The Hospital, The Clinical Journal, The U.C.L. Union Magazine, Polyclinic, South African Medical Record, St. Bartholomew's Hospital Journal, Calcutta Medical Journal, Indian Medical Gazette, Gaceta Medica de Costa Rica, London Hospital Gazette, Manchester University Magazine, The Prescriber, The Nursing Times, Charing Cross Hospital Gazette, M.S. Journal, St. Thomas's Hospital Gazette.

Carbon Dioxide Snow.

CLINICAL LECTURE BY Dr. IREDELL.

Gentlemen,—A new treatment for nævi has recently been introduced which has so many advantages over some of the forms of treatment that it will probably be used extensively in the future. Judging from a few cases in which it has been used in other conditions it seems possible that its use may not be confined to nævi alone. In the past, electrolysis has been used very largely in the Light Department for nævi of all descriptions. Now, however, it is only used for those nævi which involve the whole thickness of the lip or cheek. Radium has given admirable results, is quite painless, and needs no anæsthetic, but is slow, as a patch one inch square requires one hour once a week for weeks or months before a cure is produced. As the amount of radium is limited, comparatively few cases can be treated. With carbon dioxide snow the treatment is almost painless, takes only two or three treatments of a few seconds each, and costs very little. The cost to the hospital of a cylinder which was used daily for four weeks was less than four shillings.

The preparation of the snow was described by Mr. Finnimore in a recent number of the Gazette. A short description, however, may be of use here. An iron cylinder of liquid carbon dioxide under a pressure of 20 atmospheres, such as is used commercially in the manufacture of soda water, is placed so that it slants downwards. The gas is then allowed to escape into a bag or other receptacle. The sudden expansion of the gas causes a lowering of its temperature, and it solidifies to a substance like snow. This can be pressed into any shape, and is often used in the form of a stick or pencil. A simple way to use it is to collect some in a glass tube so that it just projects out of one end in a solid form. This is pressed on the part to be treated by means of a wooden plunger from the other end of the tube. The temperature of the solid is -79° C., and therefore evaporation takes place rapidly, and the size of the mass of carbon dioxide diminishing quickly, pressure has to be exerted to keep the end of it projecting out of the tube so as to touch the patient.

The effect produced varies with the length of time of the application and the pressure used. It is a good rule to use a constant moderate pressure and to vary the time. I consider ten seconds a standard which is sufficient to produce a slight reaction without any fear of scarring. Babies and small children require two or three seconds less, and adults one or two seconds more. Probably an application of twenty-five seconds would produce a slight superficial scar. Some authorities recommend an application of thirty or forty seconds, but I think just as good results can be obtained by shorter applications if repeated once or twice, and there is much less chance of scarring. In the longer applications the action is, practically speaking, a caustic one, as the whole area treated is equally affected and destroyed later on, though, as is the case with a severe radium reaction, the destruction takes place after an interval. In shorter applications the reaction is selective, as a nævus may disappear without any change in the surrounding skin. After the application has been made the depression produced by the pressure of the solid carbon dioxide remains, and is white and hard. This condition lasts for about the same length of time as the application, and the treated area gradually regains its normal appearance. It then becomes red and swollen. The following day a blister is formed, and when the fluid has been let out a scab remains which comes away in a week or ten days, leaving a smooth pink surface which gradually becomes normal. If a scar is produced, as is the case with a longer application, it is fine and supple with no thickening. If the case is a nævus it becomes much paler with each application, and two or three are almost always sufficient. The pain produced has been underrated. Most babies cry, and all the adults I have treated say that to call it painless is a mistake. It is, however, comparatively slight. The actual application causes a burning pain, which is continued after it has thawed for a few minutes. This is relieved at once by bathing with cold water.

Warts do very well with refrigeration, as it is called. Small flat warts are easily cured by an application of ten seconds, after which the wart comes away with the blister. Large heaped-up warts require longer treatment, and it is necessary to freeze until a narrow margin of healthy tissue all round has been frozen. The treatment of large warts, however, is not very satisfactory, and often several applications have to be made in order to ensure a cure.

The results of treating about a dozen cases of lupus erythematosus have been most encouraging. This disease differs from lupus vulgaris in being probably non-tubercular, and also in being little influenced by the Finsen light or

X-rays. It affects the nose, cheeks, and ears. All the cases treated have improved immediately after the first application. In some of the cases the diseased parts were very prone to bleed after any slight injury, and this tendency was immediately stopped by refrigeration. One patient had had the disease four years, and was cured in a month after having had three treatments. Another who had been treated with Finsen light at another London hospital for many months without much benefit is now almost well after four treatments. The other cases have done almost as well.

We have refrigerated two cases of rodent ulcer. One case is a rodent of the upper eyelid, which has now become fixed to the eyeball. It has been a most difficult case to treat either with X-rays or radium, because we have been afraid of the effect on the eyeball, and the result has been that it has been slowly increasing in size. It has now been refrigerated two or three times, the discharge has stopped, and it is beginning to heal over. The other case is a man who has had a rodent ulcer two and a half inches across on the side of the head. This ulcer had healed over, but there were two or three small thickened places left on the edge, which refused to heal with X-rays. These have cleared up after having been refrigerated. One patient with a keloid has been treated by this method. While abroad she was badly burnt on the whole of the left arm, left hand, the flexure of the right elbow, and the left cheek. All these developed keloid, and she was treated with fibrolysin injections without any result. She was then sent for treatment to the Light Department, and was treated with radium, X-rays, and carbonic acid snow. All three did good, and when she left to go abroad again she could straighten both elbows, which she had been unable to do when she came, and all the scars were softer and thinner. The part, however, that she considered had improved most was that part which had been refrigerated. A very interesting case which is now under treatment is a girl who has now been attending the hospital for some time suffering from keratosis follicularis. In this disease the body becomes covered with brownish-grey crusts. The general health is not affected, but the disease pursues a steady progressive course, and so far no case has yet been cured. She has been treated on different patches on her abdomen, and the crusts have come away in a most satisfactory manner. As the disease shows signs of affecting her hands and face, we hope to be able to prevent it from disfiguring her. Two cases of lupus verrucosus have been treated. These cases were improving very slowly with X-rays, and were refrigerated with the idea of accelerating their recovery. Three treatments at a week's interval have done as much good as three months of X-rays, and I hope that soon they will be cured. It has also been tried once or twice in lupus vulgaris in patients who have been unable to spare the time for Finsen treatment, but it is too early to say with what result. I have also refrigerated a large malignant ulcer in the neck due to the breaking down of a mass of glands secondary to growth of the tongue. The ulcer is now much cleaner, and the discharge much less than it was.

After six months of almost daily use of carbon dioxide snow I have seen no bad results of the treatment. None of the cases has developed keloid or telangiectases where the treatment has been carried out, and in those cases where scarring has resulted it has been so slight as to be scarcely perceptible.

Liquid air has also been used for freezing, but a liquid is very difficult to use, and the reaction obtained is very severe. Ethyl chloride has been used in lupus vulgaris and other conditions, but with very little success. It is unlikely, therefore, that carbon dioxide snow, which is so easily obtained, will be superseded at present, especially in the treatment of nævi and lupus erythematosus. In the other diseases which have been mentioned as having been treated more experience is needed.

Pass List.

University of London.

M.D. EXAMINATION, JULY, 1910.

Branch V.—State Medicine.

A. H. G. Burton, B.S.; F. A. Sharpe, B.S.

Branch VI.—Tropical Medicine.

J. M. W. Pollard, B.S.

Second Examination for Medical Degrees.

Part I.—Organic and Applied Chemistry.

W. L. E. Reynolds.
P. D. Scott.
H. O. F. Thompson.
W. L. Webb.
H. P. Whitworth.

Part II.—Anatomy, Physiology and Pharmacology.

V. Atienza.
R. Creasy.
A. S. Erulkar.
J. M. Joly.
W. Matthews.
H. L. Meyer.
A. G. H. Moore.
R. D. Passey.
J. A. Ryle.
C. Sherris.
A. J. E. Smith.
J. L. Stewart.
A. Wills.
W. A. Young.

First Examination for Medical Degrees.

J. E. Clark.
A. W. A. Davies.
R. W. D. C. Easom.
D. H. A. Galbraith.
H. F. T. Hogben.
N. E. Kendall.
J. Kyle.
W. M. Lansdale.
E. A. Leviseur.
H. J. Leviseur.
A. L. Punch.
K. N. Purkis.
B. Sampson.
A. G. Simmins.
J. F. H. Stallman.
J. G. Stevens.
*W. E. Tanner.

*Awarded a mark of distinction in Inorganic Chemistry.

University of Cambridge.

Exercise for Degree of M.D.

A. Sidney Morton Palmer, M.A. (Jesus).

Degrees of M.B., B.C. Conferred.

K. T. Khong (John). | H. Lee (John).

University of Durham.

Third Examination for the Degree of Bachelor of Medicine.

G. E. W. Lacey.

Final Conjoint Examination, July, 1910.

Medicine, Surgery and Midwifery.

*F. A. Dick. | *A. S. Roe.

Medicine and Surgery only.

*J. G. Blechsmidt.
A. Neville Cox.
*H. W. Doll.
*J. A. Edmond.
*W. E. Fox.
*E. A. Penny.
*R. Stout.

Medicine and Midwifery only.

J. B. Cockrem. | C. D. Killpack.

Surgery and Midwifery only.

*A. L. George.

Medicine only.

W. T. Chaning-Pearce.
W. H. T. Jones.
H. F. Percival.
J. Pryce-Davies.
*A. D. J. B. Williams.

Surgery only.

J. H. Campain.
*F. C. Endean.
*K. T. Khong.
G. T. Mullally.
*A. L. Saul.

Midwifery only.

L. C. W. Cane.
H. T. Depree.
A. L. Gardner.
G. R. Hind.
L. C. D. Irvine.
W. E. Levinson.
G. C. Lowe.
H. F. Renton.
T. S. Sharpley.
A. D. Vazquez.
E. White.

* Denotes completion of examination.

Second Conjoint Examination, July, 1910.

Anatomy and Physiology.

E. R. Bailey. | G. A. Pratt.
J. L. Lauder. | W. L. Webb.

First Conjoint Examination, July, 1910.

Parts I. and II.—Chemistry and Physics.

H. P. Price.

Chemistry only.

H. G. Dresing. | K. E. King.
H. Millett.

Physics only.

D. V. Halstead. | N. H. W. Saw.
N. H. S. Maelzar. | W. H. A. D. Sutton.

Part III.—Elementary Biology.

H. G. Dresing. | K. E. King.
F. J. Messer.

Part IV.—Practical Pharmacy.

H. G. B. Blackman. | W. K. McKay.
S. W. Coffin. | R. C. Matson.
W. A. Easton. | W. R. Pryn.
H. C. Godding. | A. F. Rook.
L. C. D. Irvine. | F. L. Spalding.
M. C. Thavara.

Royal College of Surgeons of England.

Preliminary Science Examination (L.D.S.), July, 1910.

Parts I. and II.—Chemistry and Physics.

J. W. Beacock. | A. A. R. Crowe.
C. Glover.

Chemistry only.

E. C. Nicholls.

University of London.

Advanced Lectures in Physiology.

The following scheme of Advanced Lectures in Physiology for the Session 1910-11 at Guy's Hospital has been approved :—

J. H. Ryffel, M.A., M.B.: "The Intermediate Products of Metabolism." October—December, 1910. Eight Lectures. Thursdays at 4 p.m.

M. S. Pembrey, M.D.: "The Physiology of the Embryo and the Newly-born." January—March, 1911. Eight Lectures. Thursdays at 4 p.m.

J. S. Haldane, M.D., F.R.S.: "The Secretion of Urine." May, 1911. Four Lectures. Thursdays at 4 p.m.

F. G. Hopkins, D.Sc., F.R.S.: "The Importance of Organic Chemistry in Relation to Physiology." June, 1911. Four Lectures. Thursdays at 4 p.m.

E. L. Kennaway, M.B.: "Autolysis in Metabolism." July, 1911. Four Lectures. Thursdays at 4 p.m.

Royal College of Physicians of London, July, 1910.

Frederick Taylor, M.D. Lond., has been elected Censor.

The following have been appointed Examiners for the ensuing year:—

Medicine.—Sir Cooper Perry, M.D. Cantab.

Pharmacy.—A. P. Beddard, M.D. Cantab., E. I. Spriggs, M.D. Lond.

Physiology.—M. S. Pembrey, M.D. Oxon.

Physics.—A. H. Fison, D.Sc. Lond.

Cupid in the Tube.

He (not Cupid, but another young solicitor) got in at Chancery Lane, tired after a busy morning at the office, and depressed by something much nearer his heart than business. He was going to the Exhibition, in the faint hope of casting off there the gloom which lay on his spirits.

The carriage gradually filled up as the train rushed westwards, but he was oblivious to the stops and startings, and his own gloomy thoughts were the only companions of which he was aware. He wondered, with a bitter smile, whether the Scenic Railway would help him to cast them off.

This was the cause of it all: he had proposed to the girl of his heart only a week before, and had been refused. It had taken him a week to realize how severe the blow was. They had been great friends for years, and it seemed so unpleasant (to put it on the lowest grounds) for a week to pass without even seeing her. He cursed himself for his temerity or tactlessness, or whatever it was which had so suddenly and unhappily ended their acquaintance. But search as he might among his doubts, he could not bring himself to believe that the girl he loved had no love for him; he had perhaps not chosen the right occasion for speaking, or the right words—that was all he would admit. That was bad enough! Apart from his own suffering, he felt sorry for hers, which he knew would be great, and which he had the unpleasant consciousness of having caused.

At Bond Street many people got in, and every seat in the carriage was filled except one next to him. He did not notice the people entering, but by chance (he himself would have said—by intuition) he looked up and saw who was the last to get in. It was the girl he had asked to share his life! She had evidently seen him first, for their eyes had met only for an instant, and then she had sailed on past him, ignoring the empty seat. In that instant he noticed, or imagined he noticed, signs of unhappiness and trouble in her face. He followed her with his eyes, and suddenly the determination came to him to make another bold attempt for a prize so worth winning. In his pride he had vowed he would never propose twice to any woman, and now, to his shame, he discovered that he had loved pride more than her—for a week.

Meanwhile, down the carriage she was gathering her shopping parcels into one hand, and preparing to hang to the strap for the rest of the journey. A young workman got up and offered her his seat, but his companion—middle-aged and matter-of-fact—pointed out to her the empty seat next to the one person in the carriage that she was most anxious to avoid. She was in a dilemma, as it meant either taking the seat, or attracting unpleasant attention. She capitulated, and came to the seat, her cheeks burning and her eyes studiously avoiding his.

By this time the train was well on its way to the next station; the rattle and roar of its progress helped to cover, to some extent, the poor girl's embarrassment. In a way he was sorry for her, but he could not help smiling a little to himself at the curious tricks played by Fate. He leaned back in his seat, and studied a little curl straying in front of her ear, which was the most he could see of her face. All the time the motion of the wheels kept grinding out his imagination:—"Ask her again . . . You'll win her yet. . . . Ask her again. . . . You'll win her yet. . . ." with the most encouraging iteration. He could see her reflection in the window opposite, over a child's head, and once their eyes met in the glass, which added still more to her confusion.

The train began to slow down in approaching the Marble Arch Station, and a few moments of comparative quiet, which would make speech possible. They had both anticipated that possibility—she with misgiving, he with jubilation.

"Marble Arch. Hurry up, please," the conductor was shouting. The young man's courage, now the time for its display had come, deserted him. He hesitated, and the train had started again, and "Lancaster Gate—next," had been promised by the conductor before he ventured to say:—"Miss Jefferies, aren't you going to speak. . . . ?" She turned round sharply and spoke as though to a perfect stranger. "I beg your pardon?" The train was gathering speed now, and his next words were drowned in the increasing din. "There is something I want to say to you. It is most important." She shook her head to show that she could not hear, and smiled for the first time, provokingly. He cursed the interruption of the train, and she blessed it for the brief truce it afforded.

As the train slowed down at Lancaster Gate he began at once:—"I must speak. Fate has brought you next to me." Still she shook her head, until he added in a lower voice. "People can see we know one another, and will think it strange if you refuse to speak to me." She turned towards him quickly—"Oh, that isn't quite fair! Is it?" "All's fair in love and war," he ventured.

"Please say what you have to say, and don't irritate me," she said. He began: "Last Tuesday we did not understand one another. I am sorry now for what I said. I have been thinking. . . ."

"Next station—Queen's Road." Again he was interrupted. When the train pulled up again she spoke first:

'*I* am sorry, too, about last Tuesday. I want us to forget all about it. . . .'' ''Yes, by all means!'' he cried triumphantly, ''Just what I wanted us to do!'' ''No, I didn't mean that,'' she answered, ''You're misunderstanding me on purpose. I meant that . . .' This time *she* was interrupted.

''Nottin' 'ill Gate—next.''

In the noisy silence that followed he took up her unintentional suggestion of forgetting all about last Tuesday, and planned his next move on that understanding.

There was a longer wait than usual at Notting Hill Gate, and he had time to say a good deal. He told her what misery the week had been to him, and how he had blamed himself for not calling to see her; how he knew she had been worried; and how this happy chance meeting would smooth all things out. The carriage was now sufficiently crowded to be a convenient place for talking confidences. Just as the train started again, he gave up his seat to a lady. Miss Jefferies had no time to answer all he had said, but on the way to Holland Park he studied, from his new point of vantage, the effect of it on her expression, and he could see she was mentally turning it over. It gave him a thrill of pride to imagine himself standing beside her and protecting her through the battle of life just as he was standing now beside her in the noisy Tube.

He could see now that she was surrendering. Before the train stopped he ventured to lean down and whisper to her:—''Nell, will you promise me to consider again what we discussed last Tuesday?'' She promised him with her shy grey eyes. Again he whispered:—''My darling! it will end very differently next time.'' And she didn't deny what he prophesied.

At Holland Park they talked commonplaces. He told her that he was going to the Exhibition, and she said she had been shopping and was meeting her people at the Exhibition Entrance. They laughed together over the shock her people would get on seeing him with her, and plotted to give them the slip in the Exhibition. They discussed what they should see there together: he said pointedly that there was a fine collection of rings in the Jewellery Section, which would be well worth looking at. They talked now all the time (as though to make up for the lost week), both while the train was going and while it was standing still.

At Shepherd's Bush a quaint idea struck her. She laughed merrily—''Just fancy!'' she said, ''if we had not met till Holland Park, I should still have been sulking when we got to the Exhibition.''

She looked anything but sulky when they got out together and came up to her people, whose surprise at the sight excelled even what their imagination had pictured.

''Oh, mother,'' she cried, ''I met Jack in the Tube. Was'nt it lucky?''

And her mother—in her heart of hearts—agreed, both hen and ever afterwards.

Reviews, etc.

Books for review should be addressed to The Editor, Gazette Office, Guy's Hospital, S.E. Their price should in every case be stated.

Radiumtherapy. By Dr. Louis Wickham and Dr. Degrais. Translated by S. E. Dore, M.A., M.D. (Cassell & Co., Ltd., London and New York, 1910.) Price 15s. net.

In view of the increased interest that has recently been taken in the action of radium in medicine, Dr. Dore's translation of Wickham and Degrais' work supplies a distinct want. Sir Malcolm Morris has contributed an introduction, and the authors have added notes which did not appear in the French edition, and which bring their account of their experience up to date.

The translation is good, the book well printed, and the illustrations excellent. A large number of successful cases are described carefully and accurately, and full directions are given as to treatment.

The first part of the book is devoted to the physics of radium. Its properties are clearly described, and the methods of measuring the different kinds of rays are explained at some length. We cannot help thinking, however, that in applying these facts clinically too much importance has been attached to them, and that the effect will be to confuse the reader. The clinical evidence in support of their theory of cross fire is slight, and their remarks on filtration do not always carry conviction.

The second part of the book deals with the treatment of cancer and its results. Many of the cases described are remarkable, and appear to support the hopes that have been raised of its great value in this disease. It is to be regretted that no distinction has been made between epitheliomata and rodent ulcers, the latter being included under the heading of the former. No statistics are given, and there is very little reference to failures, but we note that Dr. Wickham says that in cancer of the buccal mucous membrane ''there is no doubt whatever that in the present state of radiumtherapy it is necessary, with few exceptions, to resort at once to surgery.'' This opinion is based on the fact that the final results are not so good as those at first recorded. We suspect that this is true of growths in other situations, and can scarcely think that growths of the prostate, bladder and œsophagus, which are referred to as suitable for treatment, are likely to do better than those which are as accessible as those of the mouth. It appears, therefore, that at present radium has a definite effect on cancer, but that it is not likely to replace surgery.

The most valuable part of the book is that on the treatment of nævi and cheloids.

Papers, etc., Received.

The Spread of Carcinoma by the Fallopian Tube. By Bryden Glendining. Reprinted from the Archives of the Middlesex Hospital, vol. xix. (Ninth Cancer Report). 1910.

Mr. Glendining here describes three cases where numerous minute and discrete cancerous deposits were found in the walls of the Fallopian tube, secondary in each case to carcinoma of the stomach. Serial sections of these tubes were made, and a number of them are very well reproduced in this paper. These sections seem to show that "cancer cells floating in the peritoneal cavity are swept into the lumen of the Fallopian tube, and there come in contact with the lining, pass through the columnar epithelium to enter the lymphatic spaces of the sub-epithelial and muscular tissues, and so pass into the mesosalpinx." Secondary deposits of cancer may have entered the walls of the Fallopian tube in any one of four ways, as the author points out:—(1) Through the endothelial covering of the external surface. (2) Through the blood-stream. (3) Through the lymphatic vessels. (4) Through the columnar epithelium lining the interior of the tube. The situation and distribution of the deposits in these cases are opposed to either of the first two hypotheses. In favour of the third it is noted that in all the three cases there was an accompanying enlargement of the ovary due to carcinoma, and in each case the efferent lymphatics of the ovary showed permeation by the new growth, so that extension by them into the Fallopian tube is a possible explanation. On the other hand, the author finds that while ovarian growths histologically similar frequently show extension into efferent lymphatic vessels, he has never found them to extend back into the mesosalpinx and tissues of the Fallopian tube. Moreover, the amount of growth present in the mesosalpinx in these cases was remarkably small when compared to the amount in the inner wall of the tube. On the whole, therefore, the evidence points to the view that invasion of the Fallopian tube in carcinoma is brought about by cancer cells, which coming into contact with the fimbriæ, or being swept into the lumen, engraft themselves upon the columnar cells and thence travel to deeper parts. But at present the possibility of lymphatic permeation from the ovarian growths cannot be entirely excluded.

Papers by Guy's Men.

G. Norman Meachen, M.D., B.S. Lond., M.R.C.P. Lond.: Tuberculosis of the Skin.—*The British Journal of Tuberculosis*, July, 1910.

F. H. Pearce, M.A., M.B. Cantab., R. Rankine, M.B., B.S. Lond., and A. W. Ormond, F.R.C.S. Eng.: Notes on Twenty-eight Cases of Mongolian Imbeciles, with Special Reference to their Ocular Condition (Illustrated). —*British Medical Journal*, 23rd July, 1910.

F. T. Paul, Ch.M. Liverp., F.R.C.S. Eng.: The Pathology of Prostatic Enlargement (Illustrated).—*The Lancet*, 30th July, 1910.

J. G. Porter Phillips, M.B., B.S. Lond.: The Treatment of Melancholia with the Lactic Acid Bacillus (Illustrated).—*Journal of Mental Science*, July, 1910.

R. J. Pye-Smith, Ch.M. Sheffield, F.R.C.S. Eng.: A Case of Volvulus of the Cæcum and Ascending Colon (Illustrated).—*The Lancet*, 30th July, 1910.

R. P. Rowlands, M.S. Lond., F.R.C.S. Eng.: The Prevention and Correction of Deformity following Arthritis of the Hip-joint.—*The Lancet*, 30th July, 1910.

Thomas G. Stevens, M.D. Lond., M.R.C.P. Lond., F.R.C.S. Eng.: The Present Position of Cæsarean Section in Obstetrics.—*The Practitioner*, August, 1910.

Nursing News.

Matron's Office.

Nurse C. Moore, Head Nurse in Miriam Ward, left the Hospital on completion of her three years' training on July 23rd.

On July 26th, Nurse Cruickshank, Head Nurse in John Ward, left the Hospital on completion of her three years' training, and Probationer Forbes was appointed to succeed her as Head Nurse.

On July 26th, Nurse Marsh left the Hospital on completion of her three years' training, and Probationer I. Du Sautoy was appointed to succeed her as Head Nurse in Addison Ward.

On August 3rd, Nurse Sladen left the Hospital on completion of her three years' training, and Probationer Shepherd was appointed to succeed her as Head Nurse in Naaman Ward.

Miss Constance E. Todd, who completed her training in March, 1907, and has since been private nursing in Cairo, and Second Home Sister at the Middlesex Hospital, W.C., has been appointed Matron of the new Poor-law Infirmary at Wandsworth.

Birth.

BARKER.—On July 20th, at Madras, to Captain F. A. Barker, M.B., I.M.S., and Mrs. Barker, a daughter. (By Cable.)

Marriages.

BIRDWOOD—FINLAY.—On July 25th, at Naini Tal, India, Major Gordon Birdwood, I.M.S., to Alice Caroline, younger daughter of Colonel H. T. Finlay, D.L., of Corhagh, co. Dublin.

LEEMING—READ.—On July 14th, at Trinity Road Baptist Church, Upper Tooting, A. Norman Leeming, M.B., B.S. Lond., to Mabel Otway, youngest daughter of J. R. Read, "Beverley," Brodrick Road, Upper Tooting, S.W.

ED.—A. N. C.

GUY'S HOSPITAL GAZETTE.

VOL. XXIV., No. 578.] AUGUST 20, 1910. [SIXPENCE.

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Calendar of Coming Events and Ensuing Take-in Weeks.

August.

Thur. 25. Messrs. Lane and Fagge's Take-in (Messrs. Mills and Kahlenberg).

Mon. 29. Wills Library re-opens.

September.

Thurs. 1. Messrs. Dunn & Rowlands' Take-in (Messrs. Johnston & Peall).

October Appointment List closed.

Passim.

MEMBERS of the medical and nursing professions throughout the world must have heard with deep sorrow of the death of Miss Florence Nightingale. A great organiser, a great nurse, and above all a great woman, her influence on the profession of nursing has been far-reaching and important, and her life a lesson in self-sacrifice and devotion which will last through the years. A memorial service was held in the Chapel on Friday, 19th, and a short address delivered by Rev. E. F. Russell, Chaplain of the Guild of St. Barnabas.

THE far-reaching influence which the spirit of Guy has in the world of charity is well shown in the final report of the Guy's Hospital Children's Home which has just been issued. The primary object of this most excellent charity was to help young unmarried women with first babies, anxious to redeem themselves and ready to work steadily. With this aim work was provided for the mothers in the laundry hostel of the Hospital, and the Children's Home was founded in 1899 to look after the little ones. The mothers are required to contribute five shillings a week towards the board of their children, which they are enabled to do from their wages. The Home has now been closed since 1908, as it has been found cheaper to provide the children with foster-mothers than to run a separate institution, which was necessarily on a small scale. The financial winding up of the Home showed a balance of £197 10s. 4d., which has been handed over as a donation to the Re-endowment Fund of the Hospital.

IN another column will be found an interesting biographical sketch of a remarkable old Guy's man, Peter Hubert Desvignes, who died at Weybridge on the 14th of last month, at the age of 74. Fate led him into strange places; we cannot recall a more varied or adventurous professional career; but the memory of the Hospital, which he entered in the year 1853, remained to

the end. His will contains, *inter alia*, a legacy to Guy's Hospital of £6,000 for the endowment of four Beds and four Cots, and the Hospital is also to receive the residue of his estate, probably amounting to another £6,000, which is to be devoted, five-sixths to the further endowment of Beds and Cots, and one sixth to the encouragement of Bacteriological Research. This legacy brings the Re-Endowment Fund to well over £300,000, and is a grateful reminder of the splendid help which Guy's men gave in the starting of that Fund, when the Hospital made its big Appeal in 1896. The interest in the fortunes of the Institution, which they helped to arouse throughout the country, has borne rich fruit, as evidenced by the legacies which, in recent years, have saved the financial situation. The needs of the Hospital still call for the maintenance of the old missionary spirit. The Re-Endowment Fund must be brought up to the required half million, and there is much work waiting to be done when money is forthcoming. We content ourselves with stating these things; speaking to an audience of old Guy's men it is unnecessary to do more.

It may be announced that a sale of furniture, curios, pictures, and histological instruments, part of the property of the late Dr. Desvignes, will take place at Weybridge, on September 12th and 13th next. A few of the more costly articles will be sold at Christy's in November. Dr. Henry Willson, J.P., of Weybridge, will be glad to send catalogues or information to anyone interested.

Congratulations to the Golf Society on winning the inter-hospital golf competition. Unfortunately there is as yet no cup which could be added to the goodly collection reposing at Guy's, but this is a deficiency which we hope may soon be remedied.

Readers will note that we have omitted that paragraph so prevalent in Passim at this time of the year, stating that "despite the holiday season prevailing elsewhere, the great world of the Hospital continues its unending activity, etc." We insert this obituary, not liking to let such an old friend die unmourned and unnoticed. Nevertheless it is a fact. We unfortunately know it.

There has recently been published as a supplement to the Local Goverment Board's report, a report by the Board's medical officer on infant and child mortality. The object of the report is to determine on the basis of our national statistics whether reduction of infant mortality implies any untoward influence on the health of survivors to later years; to indicate the communities which are characterised by a continuing high rate of infant mortality, and to assess, as far as is possible, the relative value of the different factors of excessive infant mortality. The main interest from a purely medical view-point is in the first and last of these three, the second being chiefly of administrative importance. The report brings out clearly that excessive mortality in infancy implies excessive mortality in later life, and the writer gives the following as the main factors affecting infant mortality. The proportion of male to female births; the proportion of legitimate to illegitimate births; the size of the family; the number of still-births; the quality of the help given at birth; the age of the wife at marriage; poverty and social conditions; the extra domestic employment of married women; urban and rural conditions of life; conditions of housing, and the ignorance and fecklessness of mothers.

The necessity of a study of child mortality is shown by the fact that one out of three deaths at all ages occurs under five years of age, one out of five during infancy, and one out of nine deaths at all ages occurs under three months of age!

The importance of breast-feeding is emphasised; the author remarking that it is the greatest natural protection against infant mortality. It is not a complete protection, in part because breast-fed infants are often exposed to excessive changes of temperature in air-polluted rooms, and in part because mothers frequently give their breast-fed infants other food of an unsuitable character. Various recommendations

for future changes are included, and the report should be of great value in assisting medical officers of health throughout the country in combating what is undoubtedly a national scourge, namely, an excessive infant mortality.

The following letter, accompanied by six penny stamps, was recently received at the Treasurer's office:—

> "The women in this Place are like Good Mothers. Kind, gentle, tender of touch, and everything that is Good. I am only a poor working tailor, the donation is small, I wish it was more, but I am thankful. The young Doctor who attended my face was most Kind and Gentle." G. C.

On the following day another letter from the same writer arrived, this time with twelve penny stamps:—

> "God bless Guy's, and all the kind good Nurses and Doctors in the Place. That kind, good gentleman who took the abscess out of my face this morning did not hurt me in the least I think he was more afraid of hurting me than I was of being hurt."

The last sentence savours of sarcasm, but the letters serve to point the moral that a little kindness is as much appreciated by the Out-patient class as by the more well-to-do, and the old fallacy that Boro' patients do not think they are being properly treated unless they are hurt, is probably to be accounted for by the fact that they mostly are, and so miss what has come to be inevitably associated with a medical examination if by any chance it is omitted.

We see that work has been started on the entrance square of the Hospital, which is to be made level and paved with wood-blocks. We have often wondered whether the old paving stones, which served but to harbour puddles and allow the motor cars of the staff to splash the more humble pedestrians, were retained for so long because of the paving stone incident to which legend says Guy's Hospital owes its existence. Whether this is or is not so, modern iconoclastic workmen now have the matter in hand, and the entrance to the Hospital is to fall into line with the spirit of modernity which governs, or should govern, its internal arrangement.

We publish elsewhere in our issue an article on Race-Suicide. The duties which its author lays on the shoulders of medical men cannot be too strongly emphasized. By our position as the confessors of modern times, and by our knowledge of the reality and importance of the facts in question, we can do much to combat the tendency to childlessness which undoubtedly exists. Nevertheless it must be remembered that the duty of the medical man is primarily to the individual, yet this need not prevent us from advocating, and advocating strongly, the principle of fertility where no obvious bar to such fertility exists. Medicine is in reality but the advocate of Nature, helping her in her trials, and warning her in her excesses, so that our science is particularly called upon to maintain a strong attitude in what is, after all, a direct contravention of Nature.

As we go to press, our evening contemporary, the *Star*, treats us to a most embittered leader. The facts of the case were that a patient with malignant disease of the prostate, being mentally deranged and quite out of control, was transferred from the surgical ward, in which he was, to the strong-room. Being unfit for operation, he was sent to a relieving officer and thence to an infirmary, where he unfortunately died. The *Star*, among a series of remarks best left unnoticed, says, "the poor hate Guy's Hospital." The answer to this, we feel, can safely be left to the inhabitants of the Borough. Feeling assured of the confidence of public and patients alike, we can afford to admire the journalistic enterprise which must have increased the paper's circulation greatly. At any rate *we* bought one!

Appointments.

Military.

Major E. M. Pilcher, R.A.M.C., has taken up the duties of Professor of Military Surgery at the Royal Army Medical College.

Lieutenant C. H. Denyer is promoted to be Captain.

Captain S. A. Ruzzah, I.M.S., has been posted to South Canara, India, as District Medical Officer.

Captain P. S. Mills, M.B., I.M.S., has been appointed as Specialist in Radiography and Electrical Science to the Mhow Division.

Transplantation of the Cornea.

THERE have been various attempts to transplant corneæ and parts of corneæ which have, on the whole, not been very successful, and therefore any fresh efforts in this direction are of interest, the utility of the operation in cases where, the rest of the eye being good, the cornea is opaque, being obvious. One variety of operation that has been done consists in the removal by means of a trephine of a circle of cornea, and fitting into the gap a slightly smaller circle of healthy cornea removed from another eye. Another method that has been used consists in slicing away the opaque cornea with a sharp knife, until only a thin translucent layer remains—grafting on to this a healthy cornea. The method recently devised and carried out by Mr. Ormond differed from these in that the whole cornea was transplanted, dependence being placed on the fact that a large portion of conjunctiva was removed as well. The conjunctiva heals rapidly, and therefore a certain amount of nourishment is quickly insured to the cornea. In the case in question, the cornea was removed from a blind eye, the result of an injury some years ago, the cornea being comparatively healthy, but the man wishing to have his eye removed on account of pain. There was also in the ward at the same time a child with good eyes, excepting that one cornea was quite opaque as the result of a perforating ulcer. Both patients were anæsthetised in the same theatre at the same time, care being taken to use no antiseptics, but merely normal saline to wash out the eyes. In the eye to be excised an incision was made, 4mm. from the corneo-scleral margin and carried completely round circumferentially to the margin of the cornea, down to the sclerotic, and the conjunctiva and sub-junctival tissues dissected up as far as the limbus. At four points in the excised conjunctiva a stitch was inserted, and the cornea itself, together with the attached conjunctiva and sub-conjunctival tissue, removed. In the child's eye the conjunctiva was incised quite close to the cornea, around the corneo-scleral margin, the conjunctiva dissected back for a distance of 5mm., and a purse-string suture passed through the cut conjunctival edge. The central cornea was then removed with a fine Græfe's knife. The whole of the excised cornea and conjunctiva from the first patient was brought over and placed in the gap left by the removal of the opaque cornea, the conjunctival collar attached being pushed under the raised conjunctival edges. The four previously inserted stitches were passed through the edges of the conjunctival flap, at a distance of 4 or 5mm. from the cornea, and the central purse-string suture pulled tight, so that the clear cornea lay in the centre with a double layer of conjunctiva around. At the end of the operation a small portion of cornea was visible in the centre of the eye, the remainder being covered by conjunctiva. Two days later the cornea was slightly opaque, but ten days after the operation the transplanted cornea was obviously clearer, and it is hoped that it will survive.

This result is sufficiently satisfactory to warrant further trial of the method, since a considerable amount of improvement can be hoped for from alterations in the technique of the operation.

Paris Hospitals.

THERE are in Paris, at the present time, very much the same number of hospitals, both general and special, as in London; but the largest of the Paris Hospitals contain more beds than the biggest London Hospitals:—Hôpital Tenon (975 beds); Saint-Louis (1564 beds); Saint-Antoine (900 beds); Lariboisière (1086 beds). Even on paper this is so, but, in reality, the hospitals of the French capital are capable of containing many more patients than is indicated by a perusal of tables of figures and statistics. Thus, at the Beaujon Hospital, I saw a ward, calculated to hold, as indicated by a notice on the wall, 20 patients; as a matter of fact there were actually 31, when I visited the hospital, in this particular ward. Frequently, at the Necker Hospital, there were six or seven beds in use over and above the number officially indicated, say 20 or 22.

In spite of this extra number of beds, I am bound to say that the air appeared perfectly fresh. This was probably due to the large amount of window space. The wards themselves were entirely without ornament, and would have appeared very dull had it not been for the windows. Before proceeding to a description of the many things which could be greatly admired, let me offer some remarks relative to matters which did not strike me so favourably.

First, let us consider the nursing service. The nurses, at some of the hospitals I visited, were not anywhere near the standard of the nurses in London. Coarse-looking and dirty, for the most part, none apparently with any great or defined knowledge of their work, some of them even struck me as being more suitable for the work of charing than that of nursing.

Secondly, the administration of anæsthetics was very bad indeed. Entrusted, so far as I could see, entirely

to students, the administration of chloroform, which is commonly used, seemed to be governed by the following simple rule: "Continue administering the chloroform, in large quantities, and at regular intervals, until you are quite certain that the patient is not breathing; if in any doubt continue the administration."

At the same time, be it said, patients were rendered unconscious in a room adjoining the operating theatre. A notable exception to this general administration of chloroform was in M. Tuffier's clinique at the Beaujon. Here ether was very well administered, also in a room adjacent to the operating room.

With the exception of the nursing service, which, I am told, was much better before the State and Church had their last quarrel, and the administration of anæsthetics, everything else I saw was admirable.

First, with regard to the patients themselves. They were much more resolute to endure pain, and took much more interest in their own complaints, than the average English patient. Their resolution in enduring pain was wonderful. This fact is a tacit admission to the badness of the administration of anæsthetics.

I am told that a patient who pays £20 a year rent, or 500 francs, is expected, and bound, to pay four or five francs per week during his residence in hospital.

The students are a cosmopolitan crowd. Here a Turk, there a Negro, here a Roman, there a Spaniard, here an individual from Central America, there a Greek. The familiarity which exists between them and the nurses, although amusing, would hardly fill one with a sense of propriety in an English hospital.

The students treat strangers with very much the same courtesy as in England—that is, very little. They appear very keen on their work.

The surgical staff consists of a surgeon, a "chef de clinique," who assists, a "chef de clinique adjoint," who sees out-patients, and two "internes." The two internes are not fully qualified, but, I think, have rather more experience than our house-surgeons, but I should not like to make a definite statement with regard to this matter. The "externes" correspond to dressers at Guy's, but are not allowed to take nearly the same important part, during operations, as English students. In fact, the absence of multitudes of hands at a French operation struck me very favourably, but the nursing service was entrusted far too much, considering its incapacity, with the handling of apparatus, and for this reason I am inclined to think that asepsis occasionally broke down, where, I venture to think, it only breaks down very rarely at Guy's.

I attended most frequently the Necker Hospital, where the Professor of Genito-Urinary Surgery has his "clinique." Professor Albarran is unfortunately laid up by illness. A man of prepossessing appearance, a sterling clinician and operator, and absolutely honest, he is, I believe, very popular. His work is at present being done by M. Marion, who is an admirable lecturer, and bedside teacher, and a very skilful surgeon. Through the obscurity of my limited knowledge of French, it appeared to me that, in addition to these good qualities, he had a very keen sense of humour.

The two "chefs de clinique" have been most kind to me in showing me details. At the Beaujon hospital, where I have been fortunate enough to see a good deal of cystoscopic work, MM. Bazy, père et fils, rule the genito-urinary department. This is not nearly on such a large scale as at the Necker, where there are over fifty beds entirely devoted to genito-urinary surgery, but is complete in all necessary details and very well arranged. M. Bazy fils is very skilful with the cystoscope. I will go more into details, if the editor will allow me, with regard to administration and operations later, and will conclude this short article with a brief account of a most admirable way of performing and dressing circumcisions which I saw in Paris.

The actual method of cutting was very much the same as at Guy's Hospital, save that the scissors were used to cut the prepuce below the forceps which grasped and stretched it, thus ensuring a clean cut edge instead of the serrated edge which one so frequently sees produced by the novice.

The sutures for uniting mucous membrane and skin were of catgut, and eight in number. After insertion they were tied; their ends were not cut short, but clipped with forceps so as to keep them separate. A small piece of gauze, a little longer than the circumference of the corona glandis, was then taken, rolled up lengthwise, placed round and over the cut prepuce, and six of the sutures tied again over it. Another larger piece of gauze was similarly rolled over the first piece and tied with the remaining two sutures which were situated one on each side of the corona. Bleeding was thus efficiently prevented and a fixed dressing applied, which came off when the sutures came away or were cut.

It has always seemed to me that some of the bigger boys, and adults, who are operated upon for phimosis in the Guy's Out-patient department, must have quickly become very uncomfortable after leaving the hospital, and this method of dressing seems to supply many deficiencies, which are present in those methods of dressing a circumcision wound, which are usually adopted. This suture dressing, which I have seen adopted for other wounds, can always be covered with the usual dressing. I have never yet seen it adopted in England, but there is nothing new under the sun, and I do not claim it as essentially French.

RALPH THOMPSON.

Periodicals, &c., Received.—The Hospital (2), Clinical Journal (2), Nursing Times, St. George's Hospital Gazette, The Prescriber, Polyclinic, Calcutta Medical Journal, Manchester Medical Students' Gazette, St. Bartholomew's Hospital Journal, S.A. Medical Record, Middlesex Hospital Journal, "On Antipyrine and Phenacetin," by V. S. Boone.

Was Guy a Miser?

IN the collection of drawings and pictures of medical interest which was organised in connection with the recent annual meeting of the British Medical Association were two engravings, lent by Dr. Cecil Hayward, which bear on the question suggested by the above title. The larger engraving, which is somewhat crudely coloured, has the inscription: "Printed for Carington Bowles in St. Paul's Churchyard, London," but is not dated. It is entitled "False Charity," and represents Thomas Guy sitting at a table covered with gold and a box containing bank notes. The founder of the hospital wears spectacles and a kind of beaver cap; and he has crutches, one of which he is holding; with the other hand he is grasping at his money on the table, and he is glancing round apprehensively. The attitude and expression remind one of those familiar portraits of misers and moneylenders painted by the Dutch masters. The title of "False Charity" is explained by a group of three men standing at Guy's side; one of them bears a paper on which we read:—"Your charity is desired for poor sufferers by fire in ye . . . ." On the table lies a paper headed, "Plan of the Hospital," and another document which reads:—"Memoranda for making my will some time or other. To my son I'll give £50 p.an. To my daughter as long as she keeps single £50 p.an. To building and endowing a hospital & erecting a statue £100,000." The picture is therefore intended to suggest that Guy, while founding a hospital in order to perpetuate his name and fame, made only a beggarly provision for his family, and refused his help to those who had suffered in a fire. This is explained in the lines which are printed beneath the title, as follows:—

> "Zealous of future Fame, behold
> The Miser grasps his glittering Gold:
> And to enjoy his vain desire
> Heeds not the Sufferers by Fire."

The smaller engraving at the exhibition was an uncoloured copy of a portion of the larger, showing Guy at the table, but leaving out the other figures. It is simply called "Thomas Guy (Founder of the Hospital)," but it also is intended to imply that he was a miser, from the memorandum for his will which lies on the table.

The case of the rich man is a hard one, for not only has he in anticipation a camel's difficulty with the needle's eye, but in this world he is always on the horns of a dilemma, namely, this: that if he gives generously to charity, he will be accused of prodigality, or accused of base motives, or criticised for assisting this charity, and not that other; while, on the other hand, if he does not give, he will certainly be called by the world a miser.

We have seen that Guy did not escape such calumny. He left a fortune to charity, besides giving away great and small sums during his lifetime, and yet he was accused of miserliness. The charges against Guy were, in fact, three:—that he was a miser in his habits, that he gave away nothing in his lifetime, and that he neglected his relatives in order to found a hospital and make a great impression on posterity. These charges were put forward in John Dunton's "Essay on Death-bed Charity" (1728), in which Guy is classed with several other donors to charity in their wills, who were alleged to have done no good with their money in their lifetimes. From one of these, Dunton himself had had expectations, which were disappointed, so that his verdict on "death-bed charity" cannot be accepted as entirely unbiased. Moreover, on another and earlier occasion, Dunton had referred to Guy in very different terms:—"Mr. Thomas Guy, in Lombard Street . . . . makes an eminent figure in the Company of Stationers, having been chosen Sheriff of London, and paid the Fine; and is now a Member of Parliament for Tamworth. He entertains a very sincere respect for English Liberty. He is a man of strong reason, and can talk very much to the purpose upon any subject you will propose. He is truly charitable, of which his Almshouses for the Poor are standing Testimonies."

Besides this attack on Guy's reputation after his death by Dunton, there were several other pamphleteers who made similar unworthy attacks, and, as we have seen, in public prints and lampoons also, the unfortunate Founder was exposed to these baseless accusations. In 1732, therefore, in order to defend Guy's good name, the Governors issued "A Copy of his Last Will and Testament," and in the opening "Advertisement" they wrote as follows:—". . . There have been attempts to defame the memory of the Worthy and Charitable Founder . . . as doing no good in his lifetime; but heaping up a great estate with an ostentatious design of founding an Hospital at his death. Facts best answer such invidious suggestions: Many of his poor, tho' distant, relations had stated allowances from him of Ten or Twenty pounds a year, and occasionally larger sums; and to two of them he gave Five hundred pounds apiece to advance them in the world. He has several times given fifty pounds for discharging insolvent

debtors. He has readily given a hundred pounds at a time on application to him in behalf of a distressed family. These are some of the good deeds which are come to light since his death; from which everyone must be convinced, that his private acts of charity were many and great; and from their secrecy, that they flow'd from a right principle." Then follows an account of his public benefactions, to St. Thomas' and Christ's Hospitals and the Tamworth Almshouses, and the preface concludes with these dignified words: "From these instances, it is easy, to judge, on which side Charity has been wanting."

Let us examine the three charges against Guy. First: That he was miserly in his habits. Several anecdotes of his parsimonious ways became current, but how much foundation there was for them it is impossible now to tell. Nichols states that Guy "being a single man, and very penurious, his expenses were next to nothing. His custom was to dine on his shop counter, with no other table cloth than an old newspaper; he was also as little nice in regard to his apparel." The incident of his breaking off an engagement to his maidservant on account of her extravagance has recently been related in the GAZETTE under the title "Guy's Romance." A famous tale is that of Guy's interview with one "Vulture" Hopkins, a notorious miser of that time, referred to by Pope in his "Moral Essays."

The tale is told thus in *Notes and Queries* (2nd series, vol. viii., 208):—". . . On one occasion Hopkins paid an evening visit to Guy, the founder, etc., . . . who also was as remarkable for his private parsimony as his public munificence. On Hopkins entering the room, Mr. Guy lighted a farthing candle which lay ready on the table, and desired to know the purport of the gentleman's visit." "I have been told," said Hopkins, "that you, Sir, are better versed in the prudent and necessary art of saving than any man now living, and I therefore wait upon you for a lesson of frugality; an art in which I used to think I excelled, but am told by all who know you that are you greatly my superior." "And is that all you came about?" replied Guy. "Why then, we can talk this matter over in the dark." Upon this he with great deliberation extinguished his new lighted farthing candle. Struck with this example of economy, Hopkins rose up, acknowledged himself convinced of the other's superior gift, and took his leave."

If true, this anecdote would make Guy not merely a miser, but a very genius in parsimony. Of course, it is very probably not true. When a man possesses a vast fortune, when he remains single, and especially if he remains simple, not necessarily penurious, in his tastes and habits of life, gossipy tongues readily invent tales such as the above. Because he does not dine in style, waited upon by many servants, surrounded by luxury, therefore he dines in a beggarly manner, "with no other tablecloth than an old newspaper;" because he does not over-dress, therefore he is slovenly in appearance, and so on. What would be moderation in another man becomes in him stinginess; thrift, if he practises it, is called parsimony.

But no one now would think of condemning Guy even if he did dine off an old newspaper. It might be maintained as a reasonable proposition that this was the most agreeable method of dining or that this was the most suitable use for a newspaper, and in any case such a habit would nowadays be condoned as the eccentricity of a rich man. We have learned to associate eccentricity with riches as well as with genius. Probably Guy as an old man became somewhat eccentric in his habits. But he was far too good a man of business merely to hoard wealth like the true miser, and keep it out of circulation. Guy liked his money to earn interest, at as high a rate as was compatible with security, for he was above all a man of sound sense, and did not amass his great fortune by accident, though in later years possibly he did not crave greatly for further wealth, but became richer still, as we see some rich men do, through no fault of his own, so to speak.

The other two charges against Guy will not bear examination. We have seen that he gave away much during his lifetime, not only in public benefactions, but also in private charities. There is no doubt that on many occasions he helped persons who were in pecuniary difficulties. One day he was leaning over the parapet of London Bridge, gazing down on the water when a well-meaning man thinking Guy was contemplating suicide, came up and begged him to take heart again and not throw away his life. Guy of course explained that he had no such intention, but he thanked the man for his well-meant advice, and inquired his name. Years afterwards, when he came across the man's name in a list of undischarged bankrupts, he remembered the incident, and hastened to his aid, placing him once again in a secure financial position. There is abundant evidence that Guy was during his lifetime a charitable man, but here again probably his sound sense was applied, and he was no indiscriminating giver.

There was no grain of truth in the charge that Guy neglected his relatives. He had no immediate family, so that the son and daughter to whom he is made to leave £50 per annum each, were a pure invention of the artist. All his living relatives, even to children of cousins to the third generation, were remembered in his will, and received adequate bequests.

We cannot, therefore, call Guy a miser. He was essentially an astute man of business, very probably had an eye to the main chance, and very likely spent very little on himself. But to others he was a generous benefactor, and when in his later years he conceived his great scheme of founding a hospital, he was obviously justified in putting that scheme before all, and making of a grand dream a grand reality. No miser could have even dreamed the dream.

A. N. C.

The Journalistic Touch.

WE have often wondered what would be the result if a reporter of say the *Evening Mail* or the *Daily Star* were to take a surgical operation as his theme. Of course it *might* be reported as it really is, but we would suggest the following as the more probable production :—

"As I entered the theatre, for such is the name applied to the room in which operations are performed, a sense of awe stole over me. So this was the room of a hundred tragedies, this the arena in which those grim battles took place between life and death, between science and disease. Glass was on the walls, on the ceiling, reflecting a hundred times the lights which were over the table. Everywhere a note of scrupulous cleanliness from the glass table itself to the plain wooden benches by the wall, presumably to accommodate visitors or students. Further thoughts were prevented by the entry of the patient, a youth of fifteen summers, who, carried in on a trolley, was lifted to the table and lay there, anxious and expectant, awaiting the struggle which meant life or death to him. The anæsthetist, a short man with a kindly face and manner, listened anxiously to the feeble fluttering of the patient's heart, then with a few reassuring words placed a mask on the face before him and proceeded to wind round it layer upon layer of filmy gauze. Then from a bottle he dropped ether upon the mask. The patient as the first breath of the bringer of oblivion filled his nostrils, gave a cough and then lay quietly breathing until a blessed forgetfulness robbed him of the knowledge of what lay before him.

"At this moment there entered the surgeon and his attendants clad in overall, cap, mask and gloves. The surgeon himself, tall, and the embodiment of calm, examined the patient and then with a quiet 'May I begin?' cut deep into the warm quivering flesh. The fresh blood poured from the wound, but an assistant, standing by with tense expectant face, quickly stayed the flow with forceps and lint. Rapidly the surgeon worked, every movement calculated, every gesture of portent; and all the while instructing his assistant with a quiet 'Do you see? do you? do you?' to each in turn. At last the appendix, cause of all the trouble, was out, and lay innocent-looking enough to the inexperienced eye, upon the surgeon's palm. A quick examination revealed the cause of the attack in the shape of a small kink, and, satisfied that all that was necessary had been done, the wound was quickly closed with rapidly-inserted stitches, padded and bandaged, and, as the doctors have it, 'the patient returned to bed.' Scarce half-an-hour had passed since my entry to the theatre, and yet how much had happened! Another life saved; another success to the surgeon and the Hospital in which he worked, and above all another victory for Science. Yet to those engaged in the operation this was but an every-day affair, and ten minutes later they could be seen smoking their cigarettes, chatting to their friends, forgetful of the drama in which they had been actors and of the life which they had assisted to save!"

A Clinical Note on Alcohol and the Pulse.

THE patient is not intoxicated acutely. He has been taking more than his usual amount of whisky for a day or more. I can always tell him, and that correctly, when he has been exceeding that amount by examining his pulse, because I find the following sensations conveyed to my touch :—The pulse does not rise as high as usual. It is more of a long swell than a short sharply-defined impulse. The artery gives a flattened sensation to the examining fingers, instead of a roundish line forcing up against them. The impression conveyed to my mind is always that of a cowed or subjugated pulse, not an exhausted one. The number of beats may be the same as on ordinary days, but the pulse moves, as it were, with bated breath. The vessel is like a string vibrating fully and regularly with each note of equal force, but muted, or as if the passage was marked "piano." Two cases of the above were both males about sixty with sound kidneys.

These pulse characteristics were temporary, vanishing with a diminished alcohol intake. Have others had the same experience as myself?

AFTER THIRTY YEARS.

A Case of Cerebral Abscess.

CLINICAL LECTURE BY Mr. PHILIP TURNER.

Gentlemen,—I wish to speak to-day about a case of cerebral abscess which was in Clinical some three months ago under Dr. Shaw. The patient, a boy æt. 9 years, was admitted for severe headache and constipation. His previous health had been good with one important exception. A purulent discharge from his right ear had existed for some years—its exact duration and cause could not be determined. His mother stated that this had never troubled him; in other words, that it had never caused any pain, and so it had remained entirely neglected and untreated.

The onset of the present illness was gradual, but we were told that for three weeks he had been unable to attend school. The pain in his head had been continuous and severe, with occasional very acute exacerbations causing him to cry out. The constipation had been very obstinate, and there had been occasional vomiting. The discharge from the ear had ceased with the onset of the acute symptoms.

On admission he was decidedly drowsy. He could answer questions, but cerebration was very slow. The pulse-rate was 52 and the temperature 97·4°, both being subnormal. There was no paralysis of the limbs, but there was ptosis of the right eyelid, and the right pupil was dilated and fixed. On examining the right tympanic membrane there was a large perforation posteriorly through which some pus could be seen. There was no tenderness on pressure over the mastoid process. No optic neuritis was present.

All the patient's symptoms pointed very strongly to some intra-cranial trouble, and an exceedingly common cause of this, viz., chronic middle ear suppuration, was present. The next thing to consider was the nature of the trouble. Which of the intra-cranial complications of suppurative otitis media was the cause of these symptoms? The absence of high temperature, with rigors and a tender swelling in the neck, negatived lateral sinus thrombosis. The mental symptoms with the ptosis and dilated pupil rendered extradrual abscess very improbable. Hence he was suffering either from meningitis or cerebral abscess. If meningitis had been present the symptoms would have been much more acute, for a septic meningitis is usually fatal in less than ten days. Convulsions and retraction of the head would probably have been present at the beginning of the illness, and later some paralysis of the limbs.

The symptoms of cerebral abscess are often very obscure, rendering the diagnosis and localization of the trouble a matter of great difficulty. The most constant symptom is severe acute pain in the head with occasional exacerbations. Associated with this there is usually some dulness, drowsiness, and deficient cerebration. Vomiting frequently occurs and, as in the present case, there may be obstinate constipation. Occasionally there may be paralysis either of some cranial nerve or of the limbs which may help to localise the lesion. Usually at the commencement of the trouble the temperature and pulse-rate are raised, but later on, as in this case, both may be subnormal. Optic neuritis may be present, but is less frequent than in cases of meningitis or cerebral tumour. Convulsions may occur, but are unusual.

Associated with the above symptoms there will be some cause for the abscess. The present patient had the commonest of all causes, chronic middle ear suppuration, and it may here be stated that it is very common to find that with the onset of acute symptoms the discharge from the ear diminishes or may cease entirely. It must, however, be remembered that there are other causes of a cerebral abscess. Thus it may be secondary to caries or necrosis of the cranial bones, whether resulting from disease, usually syphilitic or tuberculous, or injury. It may also occur as the result of caries of the ethmoid or of suppuration in the frontal or other accessory sinuses of the nose. It may be pyæmic in origin, the primary focus being situated in some distant part of the body. Lastly, it must be remembered that a cerebral abscess may develop in a case of old-standing chest trouble, such as bronchiectasis or an empyema. In

these cases it may be exceedingly difficult, or even impossible, to localise the abscess.

When a cerebral abscess occurs as a complication of suppurative otitis media, it is usually situated either in the temporo-sphenoidal lobe or in the lateral lobe of the cerebellum. Rarely it is found at some distance from the affected ear, sometimes even in the opposite cerebral hemisphere. If situated in the cerebellum, optic neuritis is nearly always present. There may be some paresis of the limbs on the opposite side owing to pressure on the motor tract as it traverses the pons, and some ataxy is occasionally noticed. The pain, too, is frequently referred especially to the occipital region.

The absence of these signs in the present case strongly suggested that the abscess was situated in the temporo-sphenoidal lobe.

Having made this diagnosis, an immediate operation for the drainage of the pus was decided on. In former days it was usual to trephine over the suspected area, incise the dura mater and drain the abscess, leaving the septic antrum and mastoid cells either untreated, or at best but imperfectly drained. The result was that, though the patient might be relieved from immediate danger, suppuration still continued in the middle ear and the mastoid, and there was still the likelihood of further serious complications. Another drawback to this method is that, as the localisation of the abscess is often uncertain, the intra-cranial collection of pus may be only imperfectly drained, or may be altogether missed. The modern method of treatment is to commence by opening the mastoid air-cells and antrum, and then, by removing the posterior wall of the bony external auditory meatus, rapidly to do a radical mastoid operation. A careful examination of this cavity will then nearly always reveal a perforation where the tegmen tympani or wall of the antrum has been destroyed. If a probe be passed, either carious bone will be felt or the dura mater may be felt bounding the suppurating cavity. Sometimes a distinct sequestrum may be found which on removal exposes the dura. The infected tract is now traced onwards. If the tegmen tympani, which forms the roof of the tympanum and of the antrum, is carious and perforated, the pus will make its way either into the middle fossa or into the temporo-sphenoidal lobe.

If the posterior wall of the antrum is destroyed, the septic process invades the posterior fossa usually in the groove for the sigmoid sinus. In this case lateral sinus thrombosis or a cerebellar abscess is likely to occur.

It is of the greatest importance to remember that intracranial suppuration nearly always occurs by direct extension. In some cases where no obvious perforation is present the bone may be distinctly carious, or if apparently normal may be infiltrated with pus. Rarely it may be due to other causes. Thus it may travel by blood-vessels or lymphatics. It may also extend *via* the labyrinth, or may even make its way into the carotid canal and pass by means of this channel into the cranial cavity.

The particular variety of lesion produced depends to a great extent on the condition of the membranes. If the granulations around the diseased bone do not become adherent to the dura mater, an extra-dural abscess is likely to result. If the pia and arachnoid are not adherent to the dura, septic meningitis will probably ensue.

In the case we are discussing a radical mastoid operation was quickly done. The mastoid cells were infiltrated with pus and were gouged out. The antrum was of very large size, owing to erosion of its walls, and both it and the tympanum contained pus and septic granulation tissue. The tegmen tympani was extensively destroyed, so that the roof of the cavity was formed by the dura mater of the middle fossa. Bone was then freely removed in an upward direction for a distance of one and a half inches above the level of the external auditory meatus to expose freely the apex of the temporo-sphenoidal lobe. The exposed dura was hyperæmic, and when the finger was pressed against it no pulsation was felt, and it was remarkably tense. These are very important signs of the presence of pus in the brain. The dura mater of the posterior fossa, which was also slightly exposed, was normal in appearance. A large exploring needle was then thrust into the centre of the tense bulging area, and thick greenish-yellow pus was at once found. The abscess

was freely incised and a large quantity, estimated as ʒiss., of foul-smelling pus escaped. When this was examined in the bacteriological department bacillus coli was found. It is quite common to find this organism in the pus from a cerebral abscess. A drainage tube was then passed into the abscess cavity and secured in position by a fishing-gut suture. A couple of stitches were put in the lower part of the wound which otherwise was left open for free drainage.

The immediate benefit of the operation was most striking. Twelve hours after, the pain had completely disappeared, the eyes and eyelid were normal, and the mental condition showed a remarkable improvement.

The after-treatment consisted of daily dressing and irrigation. In a few days the discharge from the abscess had much diminished and a smaller tube was used, and later on a gauze drain. During convalescence, however, an interesting complication appeared. The boy developed a hernia cerebri. This commenced about a week after the operation, and increased in size for several days until it was the size of a large walnut. At first it was red and bled readily, but later its surface became black and part of it sloughed away. A hernia cerebri is a projection of brain substance through the dura mater and through an opening in the cranial bones. For its occurrence two things are necessary :—

1. A deficiency in the cranial wall, which may be produced by injury, operation, or disease of the cranial bones.

2. An increase of intra-cranial pressure, which may be due to a cerebral tumour or to some collection of pus or other inflammatory condition of the brain substance.

In the present case there was no evidence at any time of any further collection of pus, and the increased intra-cranial pressure was probably due to inflammatory exudation in the brain around the abscess cavity.

The treatment of a hernia cerebri is a very difficult matter unless the cause of the increased pressure can be discovered and removed. If due to a cerebral tumour, or other irremovable cause, it may be necessary to remove more bone to relieve the pressure. If the hernia cerebri is sliced away, and the cause of the increased pressure persists, another hernia will certainly develop. The treatment we adopted was simply to dress it and keep it clean, and when the sloughs had separated it rapidly receded, and the wound then quickly closed up.

The boy, after a stay at a convalescent home, has regularly attended my out-patients, and his condition is now in every way satisfactory.

The wound behind the ear is completely closed, and there is practically no discharge from the external auditory meatus. On examination with the speculum the cavity left by the radical operation is quite healthy and has almost healed up.

It is Rumoured

(Though not Confirmed) :—

That rubber gloves are to be provided by the Hospital for surgeons and dressers as well as for pathologists.

That curettings are to be performed by the obstetric dressers in future.

That the A.H.S.'s are to have free board and lodging.

That the administration of gas is now being taught by the dental surgeons.

That the L.D.S. entitles them to give it.

That all ward clerks and dressers are to be asked to wear "Domes of Silence."

That gags, in addition, are desirable in the Wills Library.

That the uninvited consume more beer than do the police.

That the beds are meant for the patients to lie on, not for the clerks.

That the subway is to be extended to the new school buildings, considering their importance, and the number of men who will work there.

That sputum-pots are to be emptied *after* the Medical Registrar's round.

That it is not good for sick babies to starve for hours, even in the O.P. department.

That if that does not finish them, the measles-room does (and no wonder !).

That the seats in the Chemistry Theatre are a little uncomfortable.

That the Medical Clinical Laboratory has been made fit for use.

That Paris will be quieter when "A Recent Traveller" returns.

Obituary.

The late Peter Hubert Desvignes, M.R.C.S.

By Dr. H. S. WILLSON.

There has recently died in Weybridge a man who in his younger days had a remarkable career. He came of an old family which, it was said, could trace descent from a certain Peter Hubert Desvignes, who in the twelfth century held high office under the famous Emperor Frederick Barbarossa. Be that as it may, in the 18th century the Desvignes were an influential and opulent family owning considerable property in Paris and giving their name to one of its streets, the Rue Desvignes, part of which (the writer believes) still exists near the Odéon. At the Revolution their property was confiscated and they fled from France, but one of their number (great uncle of the late Dr. Desvignes) was imprisoned and condemned to the guillotine. Twenty-four hours before the time fixed for his execution came the sudden downfall of Robespierre, and so his life was saved.

Dr. Desvignes was born in England in 1836. Soon after his birth, his father went to live in Vienna, where he acted for a number of years as architect to Prince Esterhazy, and this residence in the Austrian capital enabled his son to acquire an early acquaintance with the French and German languages, which he spoke all through his life with a perfect accent. In 1853, he entered Guy's Hospital as a student of medicine and science, and some three years later took the diploma of M.R.C.S. He then proceeded to Constantinople (his father's birthplace), and thence came the most romantic and unique experience of his career. At the eastern end of the Black Sea there was then existing an independent State, the small country of Mingrelia, ruled over by the hereditary Princess Dadiani. Mingrelia was the Colchis of the ancients, Land of "The Golden Fleece" and the Argonauts' adventures. The Princess Dadiani was in need of an European medical attendant, and her agent in Constantinople offered the position to Dr. Desvignes, who accepted it. He remained in Mingrelia about a year, and some idea of the extraordinary interest of his life there may be gathered from a letter which he wrote to his family describing his adventures. (Some extracts from the letter will be found below.) In 1857, Russia stretched out her long arm towards the Caucasus and quietly absorbed Mingrelia, the princess and her court being transferred to St. Petersburg, whither Dr. Desvignes accompanied her and remained as her medical attendant for about two years longer.

After returning to England, he obtained the appointment of surgeon to the great railway works which the late Thomas Brassey was then engineering in Italy and afterwards in Roumania, Moravia, and other parts of South Europe. At first his headquarters where at Leghorn, whence he made many journeys into the Maremma and along the Italian coast. Later he was transferred to Lemberg in Upper Austria, and then to Jassy in Moldavia. It was a rough and hard life for the most part, and he suffered from repeated attacks of ague and local fevers, but it developed to the full his skill and resource as a surgeon, and he acquired a high reputation among the staff and workmen engaged in Brassey's great enterprises. Dr. Desvignes also visited Egypt where he was for a time surgeon to the harbour works at Alexandria, and at another period he voyaged round the world as doctor on the sailing ship "Suffolk." Having seen so much of the world, his reminiscences in after life were always worth hearing.

Dr. Desvignes spent the last seventeen years of his life in Weybridge; for some years he resided at the Oatlands Park Hotel, and afterwards at "Firsdene," where he died on July 14th. Latterly, he had lived almost as a recluse and saw few visitors other than old friends.

Peter Hubert Desvignes possessed intellectual qualities of quite exceptional character. He spoke French, German, and Italian perfectly, and had a knowledge of several other languages, including Russian and Turkish. In natural history he had covered a wide range, he had a sound knowledge of mechanics and engineering; in some branches he was also a skilful practical workman. He read much, was an accurate thinker, and had a splendid memory. It will

always be a matter for regret that, with such advantages and possessing sufficient private means, he did not devote some part of his life to scientific research. As a naturalist, he might have left an enduring name.

Extract from a letter of the late Dr. P. H. Desvignes:—

"Gordi in Mingrelia,
"Sept. 17, 1857.

"I arrived here from Constantinople safe and sound about two months ago after an adventurous journey of three weeks, partly in small boats on the Black Sea, partly on horseback over the Asiatic swamps and through the immense forests of Mingrelia. It is a very wild and uncultivated country, with a very small population, there are no roads or bridges, so that the traveller is obliged to swim across most of the rivers with his horse. There is a small village in lower Mingrelia called Tong-didi. This is the capital and residence of the reigning family called the Dadians. . . . . On my arrival I found the country in revolution against its Princess, and this rendered my journey overland very tedious and difficult. However, the Russians have interfered and brought these savages in some measure to their senses. . . . . At Tong-didi there was, three years ago, a tolerably decent castle in which the Princess resided, but during the war it was plundered and burned by the Turks, so that the Princess has only her summer residences left, situated among the mountains, these being the most agreeable spots during the great heats of the summer. . . . . The Princess at present lives in a small kiosk and all the suite in separate huts. I also live in a rough wooden hut which I have rendered as comfortable as I can. . . . There is lots of shooting here, bears abound, also stags, chamois, pheasants, hares and skakallis. I made an excursion the other day into the mountains of the Caucasus where the grandeur of the scenery exceeds all I have ever seen. The costume and habits of this country are like those of the Circassians, the language of the higher classes is the Georgian, and the people in general speak a language of their own different from all others."

Specialities.

Brusson Jeune Gluten Bread.

We regret that, owing to an error in our issue of July 23rd, it was stated that the Brusson Jeune Diabetic Bread was free from starch, as shown by the Iodine test. This is not so; nor do the makers claim to produce a starch-free bread; they maintain that their bread contains a larger proportion of proteins and less carbohydrates than ordinary bread, and so, being easily assimilated and highly nutritious, is of value as an addition to diabetic diet, when a certain amount of carbohydrate is being given. As, however, the bread contains a quantity of starch, its use in diabetes is limited to these particular cases.

From the Past.

By the retirement of Mr. A. G. Prestage from the Works Department at the end of 49 years' service, a family connection with the Hospital extending over nearly 160 years is brought to a close. Mr. Prestage's great-grandfather was the master plasterer employed on the original buildings of Guy's House, and he was succeeded by his son, grandson, and great-grandson. Born in Guy Street and accustomed to play in the hospital as a child, Mr. Prestage has watched the evolution of Guy's during the last half-century and his recollections are fraught with considerable interest.

The Out-patient Department was under the Old Front Surgery, and the Dispensary was where the Grocery Stores now are, while what is now Isolation consisted then of cubicles providing sleeping accommodation for about 30 nurses. The Electrical Department was in a room at the end of the main passage in Guy's House, and the apparatus consisted of one hand machine with a single nurse in attendance!

At the top of Guy's House were the Foul Wards, known throughout the district as Guy's Garrets, consisting of two tumble-down wards, Samaritan for men, and Patience for women, while at the end of the passage was a special Itch ward, which knew no lack of patients.

Different, indeed, were the nursing arrangements in those days, the days of "Sarah Gamp." The majority of the Sisters were widows with grown children, who, employed in the city, took their meals and spent their leisure in the hospital. The Sisters provided their own food, and so numbers of tradesmen were continually about the premises. Again, a man used to go through the wards selling shrimps and watercress to the patients in the afternoon and oysters in the evening, while women sold milk and eggs, and a lame man called Trotman, or "Troty," quite a character at that time, hawked writing material and sweetstuff through the wards. Where the Bacteriological Laboratory now stands there used to be the Brewhouse yard, for the Hospital brewed its own beer in those days, and it was, indeed, included in the Hospital diet.

Perhaps one of the most interesting characters about the Hospital was Barney, the back-gate watchman. Fat of figure and of face, with a husky voice and large yellow-looking eyes, he was an unforgettable figure as he walked round the Hospital throughout the night calling the hours in a voice loud enough to wake any patient who was fortunate enough to have got to sleep.

The College was, of course, non-existent, and the Students' Club was housed in one of the wards which was closed to the public through lack of funds. The Park, which is where Queen Street used to be, was first laid out when Hunt's House, the Medical Block, was built, and still later the Medical School Buildings and the Henriette Raphael Nurses' Home were added.

Race-Suicide and the Medical Profession.

A GREAT deal has been written just lately about Race-Suicide, the Shirking of Motherhood and Fatherhood, and the like—a great deal too much, perhaps, some may think who only have their attention drawn to these subjects by horrid articles in the Yellow Press. Now and then, however, one hears an honest note of criticism or warning such as was sounded at the late Conference of the British Medical Association. The facts about race-suicide and the consequent declining birth-rate cannot be brought to the notice of medical men too forcibly, for it is to the medical profession that England looks for a cure of the most deadly disease that has attacked her since she became a nation. That this disease is a very real danger is a fact as obvious as it is melancholy.

It is merely necessary to draw upon one's personal experience to realise immediately that the family of one, two, or three, or, worse still, the childless marriage, is only too prevalent among the upper and middle classes.

The problem of race-suicide is made difficult from the outset by the fact that the causes of national sterility are so numerous. They may conveniently be classified as natural and artificial causes.

By natural causes of sterility are meant those causes which are beyond human control, and practically consist wholly of pathological conditions, *e.g.*, malformations of the genitals of the man or the woman, or both, or those rare mental conditions in which the man or the woman is unable to complete the sexual act.

Compared to the artificial, the natural causes of sterility are few and rare, and of all the bodily functions that of procreation is the one least often abnormal.

The artificial causes may be subdivided into moral, economic, and social.

The moral factor in race-suicide is by far the largest and most difficult to combat.

The widespread and increasing use of preventive measures is an insidious crime which poisons every class of society, and is becoming daily more virulent from the lack of men brave enough to stir up a healthy public opinion to crush it.

The medical profession should do all in its power to repel every attack made on the integrity of the family for the sake of the community, for the sake of the individual, and for the sake of public morality and health.

The economic causes of race-suicide are most important, and are very often the sole reason why voluntary sterility is produced. Although these are questions for the statesman rather than for the doctor, the latter can always use his vote and political influence on behalf of measures which would encourage fertility, *e.g.*, the State endowment of motherhood, decrease in income tax for every healthy child, improved conditions of and higher wages for labour, etc., etc.

The economic causes of race-suicide are chiefly found among the middle classes, who are, so to speak, between the social millstones, and whose cry so often is that they "cannot afford to have children."

The social causes of race-suicide are almost entirely confined to the wealthy, whose growing desire for luxury blinds them to their duty to the community. In present-day civilisation there is no room for the baby, whose appearance would mean a little self-denial on the mother's or father's part, and so one constantly sees that bitterest of all irony—a childless marriage, which, from a sociological point of view, is an irreparable disaster.

Legislation can do much to remedy these evils by reducing the stress of industrial conditions and ensuring greater security for the worker, also by directly stimulating and encouraging fertility by monetary aids; but the medical man can do more by instilling into all with whom he comes in contact a public-spirited attitude towards this most important of questions.

Men ought to be taught that a childless marriage is a disgrace, nay, a crime worse than murder, since instead of destroying one life it refuses existence to many.

Women should regard motherhood as the glory and consummation of their sex, instead of

which many seem to regard it to-day as a tiresome process that completely ruins the figure!

Precepts such as these would come with the greatest force and significance from the lips of medical men, who by their training and position in society should be best fitted to speak with authority on such matters.

Another way in which the medical man might aid in the abolition of race-suicide is by urging married people to abandon the practice of artificially preventing conception with the idea that the older the woman is the easier will be her confinement. This belief, which is exceedingly prevalent among the lower middle classes, is particularly disastrous, because a vicious circle is set up by the woman becoming pregnant for the first time when her youthful suppleness and staying powers are past, and protracted and painful labour ensues, the result being that she refuses to undergo such an ordeal again, and so denies herself a family and cheats the State of citizens.

In conclusion, let it be remembered that the only classes and races which are maintaining or increasing their numbers to-day are those which, from a sociological point of view, it is the least desirable to multiply.

S. W.

A Home for Dipsomaniacs.

A suburb of London, forty minutes by rail. A T-shaped hamlet with the station at the extreme end of the longer bar. Emerging from the station I get quickly beyond the street line and out along the straggling road towards my destination. Ten minutes' walk and I am standing in front of a stucco house with a high old wall stretching to the right. A knock, a ring, a wait of some minutes. Admitted at last by an anæmic servant girl, I look round as I stand in the middle of a small sitting-room. Green everywhere—carpet, furniture, wall paper, picture frames, view through the French window. Nothing remains in my memory of that room but an ever sense of green.

Enter Dr. X., the Superintendent of the Home, a tall, clean-shaven, good-looking man with blue eyes and a pleasant smile. "Genial optimist," I label him at once. He takes me out to see over the grounds, and, hatless, we saunter through the rose trees which edge the path from the window along the side of the high wall on the right, and the straggling house on the left. We skirt round the building through some shady beech trees, and come on to a delightful green slope which extends in terraces down from the house to the river's edge. There is a sound of croquet balls with attendant ejaculations from a number of men in variegated garb. "There they are—some of them," says Doctor X. I feel I am being inspected from below as a possible new comer "licensed under the Act." Closer scrutiny, I hope, quickly dispelled this idea.

As I stand watching the "Dips," some playing, others standing about, I notice one fairly common characteristic, viz., jerky movements suggestive of full doses of strychnine. Exuberant spirits seem pretty general. An Army surgeon of jovial proclivities gives vent to a forbidden thought. "I should just love a glass of beer," he says, as he enters the house. This is considered quite an excellent joke by those within ear-shot. Doctor X. leaves me for a little and I find myself near a red-faced middle-aged man puffing at a briar pipe. He is confidential on the subject of the Home, and gives a testimonial to the management.

I look round a pleasant library comfortably stocked with arm-chairs and books. One or two men are lazing over a newspaper regardless of a stranger. These are the older patients. I should judge them as the "soakers;" the silent uncommunicative drinkers: morose souls for the most part. They are a contrast to the exuberant ones on the croquet lawn. One can imagine the latter individually as the life of the mess, the camp, the smoking-room. Each, perhaps, the centre of a knot of gay companions, happy in the wild joys of the moment. How long did it all last, I wonder? What ups and downs; what troubles at home and to relatives; what battles and strifes before each came within these walls? Well, here they are to-day more or less reformed characters, and not dull ones most of them, in spite of the withdrawal of the inspiring alcohol. As I am meditating on the company, Dr. X. joins me and we proceed to his private room. I ask a few questions about the cases, but there is nothing remarkable to tell me. They come here generally in the early stages of D.T. "I give them big doses of bromide," he says, "two ounces in one-dram doses every hour, with twenty-five grains of chloral perhaps, and a dram or two of paraldehyde. The thing is to get them to sleep. That is the great thing in D.T."

"Yes," I remarked, "the last case of D.T. I treated, I put under chloroform. He slept soundly for six hours and then awoke apparently quite well."

"Exactly," says Doctor X., "sleep is *the* thing."

I ask what treatment he gives afterwards.

"Well, for the first day I give five minims of Liquor Strychninæ every two hours. I let them come to my room for these doses, as once a patient took three doses straight off—fifteen minims—and became rather twitchy in consequence. At other times I just give them gentian or some such bitter."

"How long do they stay here?"

"Well, the average is five months, but some stay a shorter time, some longer. There are some, of course, who come back. That young fellow who was with the big dog has been here before."

Dr. X. has no faith in special drugs. "Get them to sleep," seems to be his watchword. He also does not consider himself the governor of a jail. He tries to trust his patients as much as possible, and allows them outside the walls on parole. Each patient on returning has to report himself, and if he shows any evidence of alcohol he is gated for a period. Letters to and from patients pass under the censorship of the doctor, but are not necessarily opened by him. Parcels coming in must always be opened in the presence of the doctor or the secretary. As far as I can judge during this brief visit to the Home, Doctor X. seems satisfied with the results of his common-sense treatment of inebriety.

FREDERIC VICARS, M.D. Brux.

London, August, 1910.

From the Gazette's Special Pathologist.

ALL specimens—particularly those of solid tissues—should be accompanied, if possible, by a short clinical and post-mortem history, and a postal order for 2s. 6d. An extra charge of 6d. per slide is made when prepared sections are to be forwarded.

Directions to be followed in sending *Diphtietihc.t Membrane ;*—Remove as much of the membraneous exudation as possible with a pair of forceps, which have been sterilized by boiling water. Place the exudation in a small, perfectly clean empty bottle, with a well-fitting glass stopper, and forward without delay. No preservative fluid should be used. The specimen must be accompanied by a Postal Order for 5s. A telegram will be despatched immediately the examination of the specimen is completed.

Diphtheria specimens are to be labelled *Immediate.*

Specimens, Letters, and Postal Orders should be addressed to the MANAGER, Gazette Office, Guy's Hospital.

Papers by Guy's Men.

G. H. Savage, M.D. Lond. : Marriage and Insanity.—*The Lancet*, 6th August, 1910.

THE EDITOR will, at all times, be glad to consider articles or sketches, provided that they are accompanied by the writer's name and address, not necessarily for publication. Payment is a matter of arrangement, and the fees that the GAZETTE *can offer are merely nominal, but if the writer desires any remuneration that fact should be stated. Authors who desire reprints of their papers should make their own arrangements with the printers when they return their proofs.*

Sport.

Golf.

Guy's, by defeating St. Thomas's in the Inter-Hospital Golf Tournament, qualified to meet London Hospital in the Final.

This match was played on Thursday, August 4th, and resulted in a win for Guy's by the substantial margin of 7 matches to 2. The teams were the guests of the Northwood Club for the day, and many thanks are due to the Club for their kindness in granting us permission to play.

This is the second year that the Tournament has been in existence; St. Thomas's were the first winners.

It seems a pity that no trophy is provided by the United Hospitals' Golfing Society, but with the growing popularity of Hospital Golf it should not be long before a stir is made in the direction of recognising this important competition.

The Guy's Society flourishes; the next event will take place in October, at the beginning of the Session, when a prize presented by Mr. Ormond will be competed for.

The following are the individual results in the match with the London :—

LONDON HOSPITAL.			GUY'S HOSPITAL.		
J. R. Dick		0	L. Bromley...	(1 up)	1
R. F. Bridges	(4 & 2)	1	W. S. Kidd...		0
W. D. Kennedy		0	J. M. Jarvie	(19th hole)	1
T. Pendered		0	B. Blackwood	(4 & 3)	1
A. E. Herman		0	G. H. Hunt...	(1 up)	1
J. S. Jobson		0	J. G. Saner...	(2 up)	1
W. S. Herman	(3 & 2)	1	R. Creasy		0
O de B. Marsh		0	W. T. Clarke	(9 & 8)	1
O de B. Marsh		0	F. Kahlenberg	(8 & 7)	1
		2			7

Births.

BARKER.—On July 20th, 1910, at Madras, S. India, to Captain and Mrs. F. A. Barker, Indian Medical Service, Port Blair, Andaman Islands, a daughter.

GROVE.—On August 10th, at St. Ives, Huntingdonshire, the wife of W. R. Grove, M.D., of a daughter.

HOPKINS.—On August 5th, at 55, St. Andrew Street, Cambridge, the wife of F. Gowland Hopkins, F.R.S., Fellow and Tutor, Emmanuel College, of a daughter.

Marriage.

THOMAS—LAUDER.—On August 4th, at Marylebone Parish Church, by the Rev. Arthur Gould, M.A., Curate-in-Charge of South Elmsall, assisted by the Rev. W. H. Davies, Frank Leslie Thomas, M.B., B.S. Lond., L.R.C.P., M.R.C.S., of Barnstaple, youngest son of J. W. Thomas, of Hale End, Woodford, to Margaret Mary, only daughter of Alexander Lauder, of Barnstaple.

ED.—E. G. S., p.p. A. N. C.

GUY'S HOSPITAL GAZETTE.

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Passim.

THE next issue of the GAZETTE will be the annual Students' Number. We therefore request that the secretaries of clubs and societies who wish to make any announcements, to the new men especially, will send in their copy at as early a date as possible. The gibe that the new men are the only students who do not see the Students' Number is no longer true, and the number provides secretaries with the only means of reaching the whole body of new students.

MR. G. DUNDERDALE has been appointed Obstetric Resident, commencing duties on September 1st.

MR. K. H. DIGBY has been elected to the hon. secretaryship of the Pupils' Physical Society, rendered vacant by the resignation of Mr. W. M. Mollison.

IN connection with the obituary notice of the late Dr. Desvignes which appeared in our last issue, a correspondent supplies the interesting additional information that the family owned and occupied a large property at Hither Green, Lee, where the late doctor resided until seventeen years ago, when he removed to Weybridge. The property at Hither Green was then sold to the Metropolitan Asylums Board, and on it was built the Park Hospital.

ALL Mr. Shenton's friends would be glad to hear that both he and Mrs. Shenton and the yacht had escaped without damage after an exciting and dangerous adventure off Hastings. It is not so long since the daily papers informed us of the removal and launching of this yacht, named *We're Here*, which Mr. Shenton himself built and fitted out at Hampstead. Mr. Shenton was sailing along the South coast, and during the night of August 18th experienced very rough weather between Folkestone and Hastings. At the latter place he sought shelter, and dropped anchors off the town, but heavy seas came over the yacht, and the position became critical. He therefore hoisted signals of distress, and the Hastings lifeboat put off to his aid. While the lifeboat was approaching, the situation became even worse, as the yacht dragged one of the anchors and bumped on the rocks. Happily, however, Mr. and Mrs. Shenton and all hands were saved, that is to say, one hand and two dogs, none of them any the worse for their perilous adventure. Mr. and Mrs. Shenton are to be congratulated on the fact that the yacht was also rescued, and suffered no damage.

THE Adjutant of the University of London Officers' Training Corps announces that it is proposed to hold Field Days on the following dates in the season 1910-11:—Saturdays, October 22nd, February 18th, and March 18th, in addition to the inspection which is to be held on the afternoon of June 24th. He therefore requests that secretaries arranging athletic and other fixtures may bear these dates in mind so that clashing may be avoided.

A SQUALIDLY-PICTURESQUE part of the district, dear to the extern, which is likely to be improved out of all recognition during the coming few years, is the "Tabard Street area." Under this title Tabard Street and the adjoining courts and alleys have attained notoriety as one of the most insanitary and immoral quarters in South London. In the reports of the Medical Officer of Health for Southwark, it has repeatedly figured as a focus of all forms of disease, and especially of phthisis and tuberculous disease generally. There is a large amount of overcrowding in this district, and many of the houses are in such a structurally-debased and worn-out condition that they are unfit for human habitation. In illustration of this is the case of a young woman who died in the hospital not long ago, as the result of a fall through a staircase in one of these houses. Even the roadway is of a kind belonging rather to the Dark Ages than to the twentieth century, as any extern knows who has tried to cycle down the street. The neighbourhood has also an evil reputation as a haunt of vice, and has been the subject of juries' riders and Borough Council resolutions from this point of view. The whole matter has now been taken up by the London County Council, and the Housing of the Working Classes Committee is to prepare and submit to the Council a scheme for clearing the area and rehousing the people living thereon and providing an open space in the centre. The gradual work of demolition has already begun, and before many years are passed the street may be a credit to the Borough, instead of a disgrace.

BUT squalor and dilapidation have a picturesque side quite lacking in model dwellings. Moreover, the place has many historical associations. These were fully dealt with in an article in the GAZETTE of December 16th, 1905, and more recently the *Daily Chronicle* and the *South London Press* have devoted articles to the subject. Suffice it here to say that the street, up to thirty years ago, was known as Kent Street, and in former days it was the main road from London into Kent. The name was altered in order, if possible, to free the street from the ill reputation which had become attached to its former name, yet, strangely enough, one still sometimes hears it referred to as "Kent Street" by its denizens. Along this street in former days rode the Black Prince in triumph from Poictiers; here the Canterbury pilgrims started on their way to Becket's tomb; here Jack Cade and his Kentish peasants entered London in rebellion. Here, in later days, the plague raged, as Pepys and Evelyn witnessed. Here, in fiction, Little Dorrit was born. The very names of the little streets leading out of Tabard Street have a wealth of association, such as Pardoner Street, Elim Street, Etham Street, Rephidim Street, Halfpenny Hatch. The passing of Tabard Street will, indeed, have some sad aspects, for at the back of our minds is the thought that, "improve" and demolish as we may, the Tabard Street dweller is a type we have always with us, and if we turn him out here, he must settle somewhere else, carrying his habits with him, and gradually dragging down some other neighbourhood into the abyss.

IN our last issue we commented on a most unjustifiable remark made by the *Star* to the effect that the poor hold Guy's Hospital in detestation. The most effective answer to such a charge, and one which our contemporary would be capable of understanding, as it was delivered in a coroner's court, is the tribute paid at an inquest by the father of a child who died recently in the hospital. The father, who was a waterside labourer in very poor circumstances, spoke in high terms of the way in which his child had been treated by two doctors at the hospital, and said they seemed as anxious about the boy as he was. "They were thorough gentlemen," he added. The coroner remarked

that it was very gratifying to have public testimony of the work done at Guy's Hospital, especially as attacks had been made on the institution, and the jury, in giving their verdict, endorsed these remarks.

An interesting fact is recorded by the *Canadian Practitioner and Review*, in connection with the life of Dr. James Henry Richardson, who received his medical education at Guy's (obtaining the M.R.C.S. in 1847) and at Paris, and whose death has recently taken place at Toronto. "One of the most interesting incidents in the life of Dr. Richardson was his work in connection with the choice of Canada's national emblem—the maple leaf. At a meeting of citizens of Toronto, which was held to arrange for the entertaining of the Prince of Wales (the late King Edward VII.), on the occasion of his visit to Toronto in 1860, it was upon the motion of Dr. Richardson that maple leaves were adopted as the chief decoration. From that came the adoption of the maple leaf as Canada's national emblem."

Sir Constantine Holman, who died at Ramsgate on August 18th, in his eighty-second year, was a distinguished old Guy's man in the ranks of general practice. He entered as a student here in 1849, and was clerk to Aston Key and a dresser under Cock. As clerk to Dr. Hughes, Assistant Physician, he reported the first twenty-one cases of differential diagnosis of functional and organic diseases of the heart. In 1849 he gained the Physical Society's prize for reports on cases, and a paper on struma. He afterwards studied in Edinburgh and Paris, and gained the M.D. of St. Andrew's and the membership of the Royal College of Surgeons of England. Then he settled in practice at Reigate, and gained a wide and varied experience. Of stately and imposing appearance, he was known, we believe, by his intimate friends as "the Emperor." Sir Constantine had a long and active career in connection with the work of the British Medical Association, of which he became a member in 1852. At a time when the fortunes of the Association were still unsettled, in 1887, he was elected Treasurer. He was elected a Vice-President at the Birmingham meeting in 1904, and was awarded the Association's gold medal "for his distinguished services to the British Medical Association, through the South-Eastern Branch, on the Central Council, and as a Vice-President," and "further for his life-long and successful labours for the improvement of the medical charities."

Another sphere of Holman's activities was Epsom College. He had been a member of the Council of the College for some years when, in 1887, he was appointed treasurer, with a large deficit and considerable disorganisation of the school to be faced. During his term of office, extending over nearly twenty years, the finances of the college were brought into a satisfactory state, and many improvements in the school were carried out. Among many other posts on learned and charitable societies, Sir Constantine was for a time President of the Guy's Physical Society. His services to the medical profession were officially recognised by his knighthood in 1904.

Mr. Henry Collen Ensor, who died recently at his residence at Cardiff, aged 51, was well known in Wales and the West of England as an ophthalmic surgeon. He was educated professionally at Guy's, and qualified in 1885. He held here the appointment of Ophthalmic House-Surgeon, and afterwards did appointments at Leicester Infirmary, and the Birmingham and Midland Eye Hospital.

Change of Address.

J. M. Bickerton, M.B., B.Ch. Oxon., L.R.C.P. Lond., M.R.C.S. Eng., from 40, First Avenue, Hove, to 69, Church Road, Hove.

Davis A. Waite, M.A. Oxon, L.R.C.P. Edin., M.R.C.S. Eng., from 37, Westbourne Park Road, W., to "Bel Air," Woodstock Avenue, Golder's Green, N.W.

(The Editor will be very glad to receive a postcard with notes of any change of address.)

The Doctor's Smile.

GRAVITY, no doubt, has a considerable value as a professional asset, but so have smiles. There are unhappily so many occasions in the doctor's life when gravity is the only attitude possible to him, that a "becoming gravity" has crystallised into a phrase to connote an attribute which has as large a place in the popular conception of the doctor even as his stethoscope. This doctor of the popular imagination one never catches laughing. He is a most correct person, and may be described as an ideal dressed in a faultless frock-coat. He wears gold-rimmed spectacles, and an expression of becoming gravity. He is always dealing with issues of life and death; in fact, the poor fellow's patients always seem to be *in extremis*. The prognosis he gives is generally grave. He seldom takes fees, for he is a conception of the popular imagination, and to the population imagination fees do not appeal. Formerly a familiar figure on the stage, he has now, to a large extent, retired from the boards. He is, however, immortal in paint. At a hearty laugh, very likely, his frock-coat may fall from him, and beneath there will be discovered only a sawdust figure, devoid of human emotions or passions—the sort of figure one might term a "practitioner," but never a "doctor."

In real life, it is good to find, doctors are just as cheerful as other folk. They see happiness as well as sorrow, and they have their successes as well as their failures, thank Heaven! On the whole, perhaps, they see more occasions for laughter than for the shedding of tears. At the least, a "strain of comedy . . . comes every now and then to leaven" the tragedy in a doctor's life. An artist in his profession is the doctor who, himself possessing "Heraclean cheerfulness and courage," can impart it to his patients. For laughter and smiles have their professional value, and as therapeutic agents they are sometimes more useful than drugs. On this point genial Dr. John Brown has some words to say:—"Let me tell my young doctor friends that a cheerful face, and step, and neckcloth, and button-hole, and an occasional hearty and kindly joke, a power of executing and setting agoing a good laugh, are stock in our trade not to be despised. The merry heart does good, like a medicine. Your pompous man, and your selfish man, don't laugh much, or care for laughter; it discomposes the fixed grandeur of the one, and has little room in the heart for the other, who is literally self-contained." And he gives an example of a case where a joke saved a patient's life by its mechanical effect on the body:—"A comely young wife, the 'cynosure' of her circle, was in bed, apparently dying from swelling and inflammation of the throat, an inaccessible abscess stopping the way; she could swallow nothing; everything had been tried. Her friends were standing round the bed in misery and helplessness. 'Try her wi' a compliment,' said her husband, in a not uncomic despair. She had genuine humour, as well as he; and as physiologists know, there is a sort of mental tickling which is beyond and above control, being under the reflex system, and instinctive as well as sighing. She laughed with her whole body and soul, and burst the abscess, and was well."

But actual laughter of the rafter-ringing type belongs not to the sick-room; it belongs rather to the convalescent than to the invalid. Indeed, the close of a serious illness and the onset of convalescence may be marked by a joke and hearty laughter between doctor and patient, indicating that the time of hushed voices and grave faces is at an end. Lamb felt this to be one of many indignities to which the convalescent is subjected. In his essay, after describing the self-absorption and importance of the invalid, he goes on to contrast with this the relatively insignificant position of the convalescent:—"Perhaps some relic of the sick man's dream of greatness survives in the still lingering visitations of the medical attendant. But how is he, too, changed with everything else! Can this be he—this man of news—of chat—of anecdote—of everything but physic—can this be he who so lately came between the patient and his cruel enemy as on some solemn embassy from Nature, erecting herself into a high mediating party?—Pshaw! 'tis some old woman!" But to most of us the return of laughter after illness is as welcome as the return to a normal temperature after fever.

Smiles, which are to laughter as the soul to the body, may, however, have a place in the sick room even during grave illness. But a smile should mean something. One which expresses nothing is but the skeleton's grin, and excites repulsion rather than sympathy. In his doctor, above all, may a patient rightly demand that a smile shall have meaning. It may express just sympathy, or a pitying sympathy, or hope, or encouragement, or genial remonstrance, but it must express something.

Only less irritating than a meaningless smile is the smile which appears to have too much meaning if it happens to be of the wrong sort. That Mephistophelian *risus sardonicus* may be left to the lawyers, for it has no place on a doctor's face; nor has the smile which is half a sneer at the trifles which for the time being are to the patient the most important facts in existence. On the other hand, we may forgive the doctor a baffled smile when he is endeavouring to elicit the patient's history, and has instead patiently to listen to a mass of irrelevant detail, and we may forgive him a little smile of triumph when at last some significant statement helps him on the diagnostic track he is fain to follow.

Now it is quite possible for the doctor to be too cheerful. Hamlet, no doubt, is right that a man "may smile, and smile, and be a villain," but it is more commonly true that the man who does so is a bore. Hamlet might with justice reply that the bore is the worst species of villain. In a doctor, a persistent smirk or smug expression becomes particularly offensive, especially if it is combined with abundant good health and excessive optimism. Breeziness is all very well, but it should not amount to a gale. There is room for the exercise of a judicious restraint in this as in many other matters. Even the ordinary good health and spirits which a doctor, if he is lucky, possesses, may have a depressing effect on a sensitive patient. Mr. E. F. Benson, in a book full of truly human touches, has suggested this:—"... The doctor came early in the evening with that cheerful professional manner which is so dismal on some occasions." The day is long past when a profound gravity and pomposity were looked upon as the invariable manner proper for the family doctor. Such a conception belongs to the days of full-bottomed wigs and gold-headed canes. Nowadays we "trust not the man who never smiles," and if he is a doctor we do not put ourselves under his care if we can help it. But it is possible to go too far in the other direction, and a Quaker-like continuous gravity is better than untimely levity.

A chief feature, then, of the doctor's smile should be a due rarity, which imparts to it added value and meaning, like the rare promises of a man who is known to be always as good as his word, or rain in an arid land. Crabbe refers to doctors as those men "of serious words and sober style," and as "friends with whom we seldom smile." Thackeray, in speaking of the good effect which the doctor exercises over "the friends" as well as over the patient, says:—"How we hang upon his words, and what a comfort we get from a smile or two if he can vouchsafe that sunshine to lighten our darkness." And Henley, in his beautiful picture of "The Chief" among the "In Hospital" poems, has described the ideal doctor's smile:—

> "His wise, rare smile is sweet with certainties,
> And seems in all his patients to compel
> Such love and faith as failure cannot quell."

This is the smile of the man who has the natural gift of healing, or, if healing is out of the question, of the man under whose care one would be content to die.

A. N. C.

Papers by Guy's Men.

Herbert French, M.D. Oxon., F.R.C.P. Lond.: A Note on the Abuse of Purgatives.—*The Lancet*, 20th August, 1910.

Kenneth W. Goadby, M.R.C.S. Eng., L.D.S. Eng., D.P.H. Camb.: On the Prevention of Dental Caries.—*The Lancet*, 20th August, 1910.

J. F. Goodhart, LL.D., M.D. Aberd., F.R.C.P. Lond.: The Treatment of Chronic Constipation.—*The Lancet*, 13th August, 1910.

Lieutenant-Colonel P. Hehir, M.D., F.R.C.S. Edin., I.M.S.: Remarks on Ascariasis. Is there a Round Worm Fever?—*The Indian Medical Gazette*, August, 1910.

Arthur F. Hertz, M.A., M.D. Oxon., F.R.C.P. Lond.: A Clinical Lecture on Muco-membranous Colitis.—*The Clinical Journal*, 3rd August, 1910.

Fleet-Surgeon W. W. Pryn, R.N.: Tests for Colour Vision.—*British Medical Journal*, 20th August, 1910.

Specialities.

"Kolynos."

The immense importance of oral hygiene is now widely recognised; but some of the details of the subject are still matters of dispute. For example, the relative advantages of tooth powders and tooth pastes and liquid preparations are a subject of divided opinion. One school holds that the mechanical action of a powder is its most important effect, and another that this very mechanical action of a gritty powder leads to abrasion, and so to deterioration of the teeth. At present, then, the matter must remain largely a question of individual taste, and about such matters there is proverbially no point in arguing.

To those who favour a tooth-paste we can recommend a preparation known as "Kolynos," *i.e.*, "disease-preventer," which is made by KOLYNOS INCORPORATED, of 4, Farringdon Avenue, E.C., from a formula of N. S. Jenkins, D.D.S., Dresden. It consists of a basis of soap and precipitated chalk, with which are combined Benzoic Acid, Eucalyptus Oil, Oil of Peppermint, Thymol, Saccharine, Alcohol and Glycerine. The cream has therefore a distinctly antiseptic action, and it is also agreeable to use. In view of the fact that some people have a very decided antipathy to the taste of peppermint, we would suggest to the manufacturers that they should supply a similar preparation, in which either the peppermint is omitted, or some other flavouring material substituted. The cream is put up in collapsible tubes, which is unquestionably the most convenient and economical method. The preparation is also supplied in bottles in liquid form, and may be used as a mouth wash or throat spray. Reports show that "Kolynos" exerts a decided antiseptic effect on the diphtheria bacilli and streptococci in cases of sore-throat, and on the bacillus of influenza.

A New Thermometer Case.

(Registered.)

I wish to draw the attention of the medical profession to a new thermometer case which Messrs. Down Bros. have made for me. This case is divided into two chambers, which are separated by a perforated partition. The smaller chamber screws on to the larger, and is made to contain a small portion of a formalin tablet. The formaldehyde vapour liberated from this tablet passes up through the perforations into the large chamber, in which the thermometer is carried. The advantages of an antiseptic thermometer case are obvious, and this case contains no fluid, which would leak into the pocket. It is only a quarter of an inch longer than the ordinary case, and is sold by Messrs. Down Bros. at the moderate price of 2s. 6d.

F. W. MORTON PALMER, M.B., M.D.

Teignmouth, Aug., 1910.

Oasis.

FOR weary feet and souls that are sick
With tramping London highways,
For eyes bedimmed with the sight of brick,
And the dust of Borough bye-ways,
There's only one cure,
I'm perfectly sure;
(It even surpasses beer,)
And the Park at Guy's,
In summer, supplies
This wonderful panacea.

Here plane-trees flutter their lordly tops
On multi-scented breezes,
(Please note the predominance of hops)
And a respite from disease is.
In the midst of wards,
With their countless hordes
Of halt and maimed humanity,
There's still to be seen
A morsel of green
That savours of sun and sanity.

Here Sirens sit in lavender frocks
And fascinating poses,
And sultry youths in sultrier socks
Deliberate diagnoses;
And plump pigeons coo,
As they always do,
With monotony incessant,
While the children shout
By the fountain's spout,
And existence seems quite pleasant.

* * * *

Ah! me, but I dream of summers passed,
Oblivious of our climate;
For isn't this August worse than last—
Enough to confound a Primate?
And besides the rain,
We're obsessed again
With scaffolding, bricks and mortar;
But I'll keep the name
Of my rhyme the same,
Though oases are *blessed* for water.

R.

Malignant Disease of the Pharynx and Larynx.

CLINICAL LECTURE BY MR. F. J. STEWARD.

GENTLEMEN,—They are so closely connected, both anatomically and clinically, that it will be well to consider malignant disease of the pharynx and larynx together.

First, as to the pharynx: epithelioma is the common form of malignant disease, but it is important to realise that clinically two different types of the disease are met with, although histologically they are the same condition. The common type of epithelioma of the pharynx occurs mostly in men above middle age, and starts low down, its position being limited to the laryngeal part of the pharynx; and, as a rule, it is the lateral wall of the pharynx which is primarily affected. Apparently the growth ulcerates early, and soon after this, or possibly even before, the lymphatics are infected, and consequently the deep cervical glands which drain that portion of the larynx become enlarged and indurated. As the primary growth is small, and is situated in the lateral and lower part of the pharynx, it does not tend to produce much in the way of symptoms, and, as a rule, there are no throat symptoms in the early stages. The first indication, therefore, that the patient has anything the matter with him is, usually, the formation of a hard mass of malignant glands in the neck, usually somewhere near the bifurcation of the carotid. There may be some discomfort in swallowing, but usually there is no symptom of anything wrong inside the throat. The question arises: What may this mass in the neck be due to? It is necessary in any case of that kind to examine carefully the mucous surface from which the lymphatics arise and into which they drain, corresponding with the affected glands. You can see the oral portion of the pharynx well; and with the pharyngeal mirror you can see a small part of the laryngeal portion. But the lowest inch of the pharynx, that part which surrounds the cricoid cartilage, you cannot see at all. An ulcer or tumour in that situation is not seen by the ordinary methods of examination. Neither can you see in these lateral extensions, the pyriform sinuses. The only satisfactory way of examining these parts of the wall of the pharynx is to give an anæsthetic, and examine the surface by means of the method which is known as Killian's direct method, a special tube spatula being passed down and illuminated by an electric lamp.

By this means in most cases you will find that there is a small malignant ulcer on some part of the pharynx on the corresponding side to the enlarged glands, although even then it is sometimes difficult to obtain a view of the far recesses of the pyriform sinus. Hence some of these small primary growths are not found at all, and they do not reveal themselves until some time afterwards. To give you an idea of what may happen, I will mention the main facts in a case, that of a man who is still attending Throat Out-patients, and has been for some considerable time. Rather more than a year ago when he came up he was 53 years of age, and he had a mass of glands on the left side of the neck. I concluded they were malignant; they were very hard and fixed, and exactly like malignant glands are; and I remember saying they were probably due to malignant disease of the pharynx. He had at this time no signs or symptoms of anything the matter inside his throat. I took him into the hospital, and examined him under an anæsthetic by Killian's apparatus, but still failed to find any primary growth. That being so, I thought the mass was possibly due to malignant disease arising primarily in the remains of a bronchial cleft, as this condition is occasionally mistaken for a mass of malignant lymphatic glands. There-

fore, with the idea of clearing up the diagnosis, I explored the mass and removed it. On examination it was found to be a typical mass of secondary epitheliomatous glands. Apparently he was well for two months. Then he attended out-patients again, when he had difficulty in swallowing and some pain, and brought up some bloody mucus. He also had a cough. One could now see, projecting up to the left side of the epiglottis, what was the upper extremity of a mass of malignant disease. There is no doubt that all the time he had epithelioma low down, slow-growing, and hidden in the depths of the pyriform sinus.

I think I have now mentioned the outstanding features of this particular condition, the chief points to remember being that the primary growth is very small, and produces no symptoms on its own account; it tends particularly to start in those outlying recesses of the pharynx, either low down by the back of the cricoid, or laterally at the side of the pharynx; and it rapidly causes enlargement of the cervical lymphatic glands. The other clinical variety of epithelioma of the pharynx is in many ways the exact opposite of the condition which I have just mentioned. It commonly affects females, and it is more common under forty than over. The majority of cases I have seen have been in young women about thirty years of age, and I suppose I have seen between twenty and thirty cases. Here are the ages and sex of the specimens in the Museum of epithelioma of the pharynx of this type: woman aged 32, woman aged 28, woman aged 24, man (age not given), woman aged 31, woman aged 33, woman aged 32, woman aged 57, woman aged 60, woman (age not given). So you see the great majority of those cases are in women, and most of them comparatively young.

The next point is that instead of a small primary ulcerating growth there is a large primary growth, which does not seem to ulcerate much, but sprouts freely and fills up the cavity of the pharynx. It, like the other form, occurs in the lower part of the pharynx, so that in the early stages it is out of sight, and only later does it sprout upwards so that you can see it with the laryngeal mirror. It distends the lower laryngeal portion of the pharynx by the production of large masses of growth, so that the first symptom is usually obstruction, combined, perhaps, with some pain on swallowing. Unlike the other variety of disease which I have mentioned, the glands are not enlarged in these cases, at least not until quite late in the course of the disease. I have seen patients who have been practically dying, and yet one could not feel any enlarged glands in the neck. We had a patient in the ward a week or two ago, a young woman who had a large mass in the lower part of the pharynx, which caused much difficulty in swallowing and some pain. When we examined her we could see the top of a mass, more on the right side than on the left, and it was gradually growing upwards over the back of the larynx. While she was in the ward, and I was considering whether it was possible to do anything radical, she developed laryngeal obstruction, and tracheotomy had to be done. I have specimens here which illustrate this variety of growth very well. Here is one with a large mass of growth in the lower part of the pharynx, involving the wall all the way round, spreading up the back of the cricoid, and involving the arytenoids, and spreading over the top of the larynx. In this specimen, again, there is more ulceration and less new growth, and there are other specimens in the museum which illustrate that variety very well. There are, therefore, two very distinct clinical types of the disease, though histologically there is no difference to be made out.

I have not said very much about diagnosis, except as regard method of examination in the

first class. In these cases it is fairly clear from the outset that the patient is suffering from malignant disease, because the glands are so definite, hard, and fixed. But in the second class of case, that of the young woman with a growth in the lower part of her pharynx, there may be considerable difficulty in diagnosis. This type of disease is apparently so little known that it is often missed altogether. A number of the cases I have seen, both at hospital and privately, have been sent as cases of intractable sore throat. Others were sent as probably laryngeal phthisis. The last patient we had in was sent by an old Guy's man, a very good observer. This woman puzzled him a good deal, though he examined her several times. At first he could make out nothing to account for her symptoms, but after a time he noticed the swelling of the arytenoid region, and he concluded that because she had such great pain on swallowing, it was probably laryngeal phthisis. But he could find no signs in her chest, and she had no tubercle bacilli in her sputum. At that stage he sent her to me, telling me the above facts. The first thing seen was a swelling in the region I show you, due to œdema of the arytenoids, caused by the growth below creeping up the back of the cricoid. Swelling of the arytenoid cartilages, associated with pain on swallowing, is commonly present in laryngeal phthisis. Therefore, the means of exclusion are the points I have mentioned; the absence of tubercle bacilli in the sputum, if there is any sputum, and the absence of signs in the chest. If the latter are not present you should suspect epithelioma of the pharynx. The diagnosis will become clear on examination by the direct method under an anæsthetic.

There is practically no treatment for these cases. Supposing you see a man with a very small epithelioma of the pharynx, and glands in the neck only slightly enlarged and fairly moveable, it is conceivable that some attempt could be made to remove the whole mass. You would have to remove a large area of the wall of the pharynx, if it was on the outer wall, and the corresponding glands. There have been a few cases in which that has been done successfully and recurrence avoided. In the majority of cases, however, the disease has recurred quickly after the operation. If the growth is in the pyriform sinus and spreading up the back of the tongue, and upwards and inwards towards the base of the epiglottis, it is clear that no radical operation can be done which does not include removal of the whole of the pharynx and larynx. That has been done in a number of cases, but it is a very severe measure, the chances of success are very slight, and it means a permanent tracheotomy opening above the sternum. Secondly, there is the question of feeding. Professor Glück, of Berlin, who has taken up this subject, and has probably operated on more of these cases than any other surgeon, overcomes this difficulty by introducing a rubber tube from the mouth into the œsophagus. And he has met with great success in a few cases. I saw, some time ago, a patient of his whose pharynx and larynx had been completely removed. Both the specimen and the patient were shown two years after the operation. The patient looked a perfectly healthy man, and on meeting him you would not realize that there had been anything the matter with him. He wore a muffler inside his coat, and this hid his permanent tracheotomy opening. He had a rubber tube for swallowing, which fitted quite satisfactorily. Glück puts in purse-string sutures and draws the parts together as much as possible, and fits the funnel-shaped tube in.

There is, of course, a gap between the base of the tongue and the upper end of the œsophagus, and you would think saliva must escape from the mouth down by the side of this rubber tube, and so keep up a constant cellulitis in the neck, and the formation of fistulæ. I think that is what happens in the bulk of cases; and Professor Glück says it is with regard to these

tubes and the question of leakage that most of the trouble arises, but in this case it was a perfect success; he had no sign of fistula, the tissues in his neck were supple, and he could swallow solid food, though he had to wash each mouthful down. His speech was entirely gone, but he could make himself understood by whispering, using a certain amount of air which he took into his mouth when he wanted to do so. He could also smoke a cigarette, and said he enjoyed it. I think that is absolutely the best result you could expect, but, of course, even this, miserable as it must really be for the patient, is very rare. However, it is as well to know what the best possible is when you have to put before the patient the question as to whether an operation should be attempted. If no operation is done, the disease will, of course, progress and cause death in a short time.

With regard to the treatment of the second group of cases, the question is much less difficult, because there are so few symptoms that the case is usually hopeless when first diagnosed. In the patient I have mentioned, who was in Ruth ward recently, we found that her cricoid cartilage was very near the upper end of the sternum, and as one knew that the division of the œsophagus would have to be an inch below the cricoid, it did not seem possible to do this without the œsophagus collapsing into the superior mediastinum. The consequence would be mediastinitis, and death from that. And altogether the growth was so advanced, and the patient so feeble, and she had to have tracheotomy done so soon after entering the hospital, that it was clear it was too late. That is usually the case. In the few cases in which I have attempted an operation, I have had either to abandon it by finding the growth was extending so far down that I could not get beyond it with a fair prospect of holding the œsophagus up; or the disease recurred comparatively quickly.

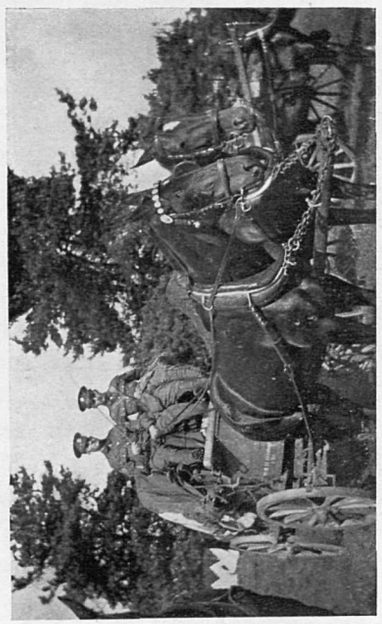
Epithelioma of the larynx may commence in any part of the mucous membrane of the larynx, but for certain reasons the cases are divided into two groups, which are known as intrinsic and extrinsic growths of the larynx. Intrinsic epithelioma of the larynx is a term applied to epithelioma which starts within the cavity of the thyroid cartilage. The commonest position is the vocal cord itself. Intrinsic epithelioma is a very slow-growing form of malignant disease which spreads locally and does not involve the glands. It usually starts as a warty thickening of the cord, which causes hoarseness, and the laryngeal mirror shows some irregularity of one cord, the other remaining quite normal. It gradually infiltrates the deeper parts, and involves the muscles which move the cord, and consequently the cord tends to become fixed. Let us consider further the clinical history of a case of that kind. As the growth gradually extends, the next symptom it produces is obstruction. As the growth occurs in the glottis itself, it will cause obstruction comparatively soon, because the space between the vocal cords is the narrow portion of the glottis. After a time it will either spread through the larynx to the tissues outside, or by extending up the lateral wall of the larynx it will reach the pharynx, and then the glands will become involved. If it starts higher up, it will reach the epiglottis, and go round the corner into the lateral aspect of the pharynx. It then becomes a type of extrinsic growth. But if it begins as an intrinsic growth, its growth is very slow, and the type of malignancy low. In this type the treatment consists, in the early stage, of removing the growth locally from the larynx by laryngo-fissure or thyrotomy, the disease being cut away with a fair margin of healthy tissue. In a fair proportion of cases so treated in early stages no recurrence takes place.

Now we come to the extrinsic varieties. These are of two kinds: those in which the growth is primarily intrinsic, and afterwards becomes

The Lines.

First Aid.

(*Photos by* H. C. GODDING.)



A General Service Waggon.

"Load Stretcher."

(*Photos by* CHEW, *Aldershot.*)

Major Herringham and Lieut. Layton.

(*Photos by CHEW, Aldershot.*)

Col. James at the Head of "B" Section.

LONDON UNIVERSITY O.T.C. CAMP (Medical Unit).

August, 1910.

extrinsic; and, secondly, there are the cases which are extrinsic from the first. The starting-point is the upper opening of the larynx, commonly at the epiglottis, and spreading outwards beyond the larynx, and downwards into the larynx proper. There is some difficulty in swallowing, with pain and usually cough; and on examining the larynx there is usually an obvious swelling with an ulcerated surface. These growths do not follow the same course as the intrinsic growths, but as regards their clinical course more resemble growths of the pharynx. The growth is rapid, and the lymphatics are early involved, so that you may find that there is a large mass in the neck by the time the patient has got any symptoms of epithelioma of the epiglottis at all. Radical operation with the object of curing extrinsic disease is not likely to be attended with very great success. In the cases of epithelioma of the epiglottis, however, a good deal can be done in the way of relief. The patient soon gets much obstruction in breathing and swallowing, and relief for many months can be secured by removing the growth with the epiglottis down flush with the patient's tongue. The result is very satisfactory in its immediate effects, but, of course, it does no permanent good.

A few of these cases have been treated by excision of the larynx, but the results have seldom been successful. If there is an ulcerative process going on on one side involving the arytenoid, and the aryteno-epiglottidean fold, and spreading some distance down the pharyngeal aspect of the larynx, and if the disease is limited and local, as shown by laryngeal examination, and by the direct Killian method, and if the glands are not involved to any extent, it may be possible to cure the patient by extirpation of the larynx.

The prognosis of the various classes depends entirely on the facts which I have given you; the greater the degree to which the mucous membrane of the pharynx is involved in any particular case, the more hopeless is the prognosis, and the less the degree to which the pharynx is involved, the more hopeful it is, if a satisfactory operation be performed.

London University Officers Training Corps.

The Camp.

The Medical and Engineer units of the L.U.O.T.C. held their second annual training at Nursery Camp, Aldershot, during the first fortnight of August, the Infantry being in a separate camp at Camberley. A most successful fortnight in camp was spent, and all ranks seem to have had a most enjoyable time.

On July 27th, an advance party of twenty men, under the command of Lieutenant Layton, went down to pitch the camp. Lieutenant Layton, with the assistance of Sergts. Yeoman (R.A.M.C.) and Redmond (R.E.), made such excellent arrangements that the camp was completely finished on the night before the main body arrived. Those who took part in the advance party seemed to have liked it as much as, if not more than, the rest of the camp. Lieutenant Layton was indefatigable and did the work of two men.

On the arrival of the main body, training was soon in full swing. A typical camp day was as follows:—

5·30. "Reveillé."
6·15—7.30. Squad and Company Drill.
7.30. Breakfast.
8.45. Tent Inspection.
9—4. Field-day—Tactical Exercises with a Field Ambulance.
6.30. Dinner.
10·15. Lights out.

On a field-day the four medical sections performed the various duties of a section of a field ambulance in turn. Thus a section would pitch the tent division camp or the dressing station on one day, and would act as stretcher bearers on the next. This arrangement broke the monotony and served to make the field-days more interesting.

By the courtesy of the regular medical officers in Aldershot the medical unit on two occasions were enabled to inspect military hospitals. During a visit to the Cambridge Hospital the

progress of a sick man was traced from the time he went on sick parade to the time he was discharged fit for duty. All the arrangements are carried out with military precision and do not in the least suggest "red tape," but perfect method. In the hospital dry stores each ration is carefully weighed out, and the storeman has to make good deficiencies to within a few ounces.

The medical unit of the Edinburgh O.T.C. were completing their training at Aldershot, and arrangements had been made for the London corps to take over the former's transport. The horses proved excellent workers under Sergt. Robinson's excellent management, thus making up for what they lacked in looks. With regard to the transport, last year the corps depended on the A.S.C. for horses, so that field operations could not be undertaken frequently. This year, however, with two sets of equipment and horses, the medical unit were able to take the field as often as required. Sergts. Robinson (Guy's) and Paget (Middlesex) are to be congratulated on the way they managed the horses; indeed, on many nights these two got very little sleep. It says much for their experience and keenness that the horses never once stampeded, and were returned to the London contractors in excellent condition.

The corps owes much for the success of the camp to the enthusiasm and patience of Colonel James, who, as usual, directed operations during field-days.

In the evenings Aldershot provided plenty of amusement. Boating on the canal, the theatre, and the various mess rooms, each attracted its own votaries. Sing-songs were organised in camp, and B. Section (Guy's and St. Thomas's) contributed performers. Sergt. Cowtan's renderings of Harry Lauder's songs, and Cadet Hancock's "Widdicombe Fair," and "Farm Yard Imitations," were enthusiastically received.

The Infantry unit challenged the combined Engineer and Medical units to a cricket match. A representative team and a good body of partisans went over in ambulance waggons and enjoyed an excellent match, which ended in a draw.

On inquiries being made for the best water-polo team in the Aldershot Command, the Scots Guards were named, and forthwith a challenge was despatched. Lieut. Layton, Corpls. Lindow and Pern, and Cadets Yorke Moore, Matthews, Thornton and Jardine, represented the corps, and beat the Guardsmen by eleven goals to two. This victory gave the camp a great reputation in Aldershot.

Captain Davies-Colley was regrettably unable to attend camp. He was universally missed, and it is to be hoped that he will be able to come next year.

Considering the corps has only been in existence two years, it is remarkable how well arranged the camp was. Of those who took part in it few went away who were not altogether pleased with their experiences, and it is to be hoped that most men will sign on for a further year's training.

[Some photographs illustrating the life and work of the camp are published as an inset. We may add that some forty different subjects of the O.T.C. Camp are published, and may be obtained from Mr. J. M. Chew, Photographer, of 30, Grosvenor Road, Aldershot, who has kindly allowed us to reproduce several of his photographs in this issue.—Ed. G.H.G.].

Appointments.

Civil.

OUTRED, C. D., M.R.C.S. Eng., L.R.C.P. Lond., has been appointed Medical Officer of Health of the Borough of Gravesend.

RANKINE, ROGER A., M.B., B.S. Lond., M.R.C.S., L.R.C.P. Lond., has been appointed Assistant Physician at the Crichton Royal Institution, Dumfries.

Military.

Lieutenant H. G. GIBSON, R.A.M.C., is promoted to be Captain.

Lieutenant F. A. BARKER, M.B., I.M.S., is promoted to be Captain.

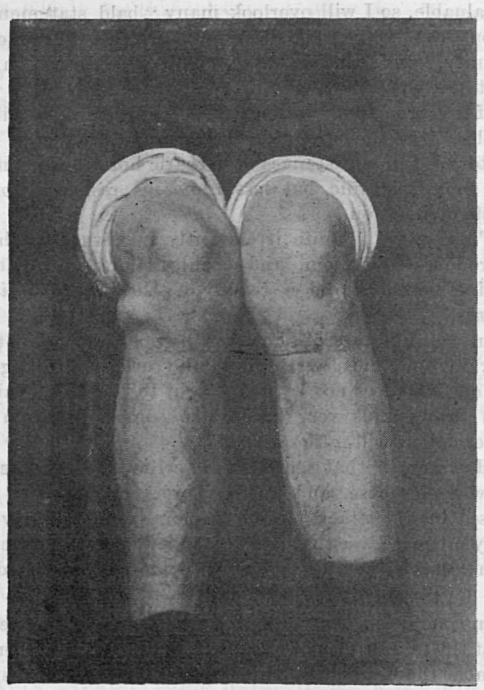
Capt. P. S. MILLS, M.B., I.M.S., has been appointed Specialist in Ophthalmology to the 5th (Mhow) Division.

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

An Occupation Bursa.

DEAR SIR,—The accompanying photograph may be of some interest to you as being an unusual variety of occupation bursa. The patient was a layer of carpets, and the bursa, as the photograph shows, was well defined and prominent over the head of the right fibula. It was



not inflamed and did not give rise to any inconvenience, the patient coming to Medical Out-Patients for heart trouble. An X-ray photograph of the leg was taken to be sure that the lump was not connected with the bone, and it showed that the fibula itself was perfectly normal.—I am, dear Sir, yours faithfully,

HERBERT FRENCH.

Another View on Race Suicide.

SIR,—I have read with interest, not unmixed with wonderment, the article in to-day's issue of the GAZETTE upon Race Suicide. It is a comfortable armchair sort of article, an instruction to the slaves of Medicine to preach the doctrine of large families as an article of faith without which —— what? The general public that reads its *Daily Mail*, and perhaps its *Times*, demands more than a bald statement, nowadays, from the family doctor. It has the temerity, the impudence even, to argue with him and require proofs and counter-argument to meet its destructive criticism. When I tell the young husband that it is decreed by Their Representative Majesties, the Council of the British Medical Association, that families of one, two, and three must in future be replaced by not less than four, and preferably of the eighth magnitude, I have to meet some such statement as follows:—

"The inevitable result of civilisation is to raise the standard of minimum comfort. When we could not read we went to bed at dusk. Now we want light. I need not labour what is at least self-evident.

"A second result is an absolute prolongation of individual life, a third the reduction or abolition of the possibility of large epidemics in which the population is decimated or even halved. Wars, too, are tending more and more to the impossible, and even in our present imperfect state do not make a material difference to the magnitude of the population. At the same time the modern competition of life makes the problem facing each unit of the population more and more difficult. Then there is another factor which does not receive the amount of attention that it should. You must consider the woman in the case. No one will deny that in the vast majority of cases the period of pregnancy, to say nothing of the lying-in, is one of great discomfort to the average woman. The more refined—to use a loose expression—she is, the more she will feel this discomfort. She protests against the size of the burden she is asked to bear, and demands its alleviation. Every decent-minded woman wants to bear a child at least, but she does not want to spend her life—her young life—in perpetual discomfort. Mind you, I do not refer to the 'Smart Set' woman, but the ordinary home-loving middle-class woman.

"Is it to be wondered at, then, that the upper, middle, and lower divisions of the middle class, both husbands and wives, agree to limit their families? The father wishes to give each of his children as good a start in life as he possibly can. The mother wants a reasonable amount of comfort in this life. Selfish, of course, but is it not carrying altruism to an absurd extent to say that each and all should multiply to the maximum in order that as many as possible should have a chance of living? Just living, that is all. It is true that the poorest and most thriftless of the community have the largest families, because they are poor and thriftless and do not care. Are we to emulate them? Am I, who can just afford, on my salary, to bring up two children decently, educate them properly, and start them with as good a start as I received myself, am I to beget eight to fight for the scanty crumbs that will result when my income is apportioned? Should I rather not seek to prevent the wastrel from putting large families on to the market for others to support? And supposing the nett result of this is that the highest races in the scale of civilisation do decrease in number, as is predicted, there will surely arrive a time when the slackening of the tension will encourage once more an increase in the

number of offspring, possibly (but this is a most immoral suggestion of mine) by a plurality of wives. The present civilised races will only be replaced by a race of higher civilisation. Numerical superiority alone will be useless. The new race must be better. Why, then, seek to block the elbow-room of the world in the wild fear of race failure? Why? why? why?"

I have not been able to give him a satisfactory answer yet. I have not even been able to satisfy myself that he is talking nonsense. Socialism as it stands to-day, exemplified by its supporters, seems to me to be a most pernicious will-o'-the-wisp, but every man who works for his living must agree that the future will recognise no one who does not earn his right to live. Education will bring this Utopia, in the end, but none the less surely, and I fail to see why the useful productive middle classes should seek to combat the wastrels of this life by mere force of numbers.

Enough of bald dogmatism. Let us have a little cold reasoning. Cold, Mr. Editor, not hot words of scorn and opprobrium.—Yours, etc.,

August 26th, 1910. S.

[The author of the article on Race Suicide writes as follows in reply to the above:—

Through the Editor's courtesy I am able to reply to the above criticism without delay.

The author has either unintentionally or wilfully misunderstood the spirit of my article on Race Suicide. It was an attempt to appeal to medical men to use their influence to arouse a clean and public-spirited attitude towards conduct which is a gross betrayal of the most sacred obligation that Nature has put upon us.

It is not the British Medical Association who bids a man refrain from ignoring this sacred obligation, and from being a traitor to himself and his race, but the voice of Humanity pleading for the super-race that is to be.

The modern competition of life makes the problem facing each unit of the population more and more difficult, but this is chiefly our own fault, and is an artificial condition of society which could be remedied by sane action and forethought, and by cultivating our social instincts. Because present-day conditions have destroyed the souls of many of us, are they also to destroy our bodies, deny us offspring, and abolish the home? Would not the wisest plan be for every man to work on the side of reform and at the same time breed a race of strong clean-minded men and women, to carry on the work of social emancipation to a glorious consummation?

We come next to "the more refined decent-minded woman of the ordinary home-loving middle-class, who wants to bear a child at least, but does not want to spend her young life in perpetual discomfort, who protests against the size of the burden she is asked to bear, and demands its alleviation."

Well, if such a paradoxical creature exists, I would suggest that the following questions be put to her:—

Does "refinement" manifest itself by shirking responsibility? Is it "decent-minded" to use preventive measures? Can a house where no children are to be found be called home? Is a family of one desirable, either from the child's or the parents' point of view? Is it not possible that after man had diminished the size of her "burden" by the most rigorous immorality, that the decent-minded woman might find less real enjoyment in her uninterrupted round of frivolity than in carrying out her normal function as a maker of men?

The next paragraph of "cold reasoning" from the "young husband" who reads the *Daily Mail*, and which my critic cannot satisfy himself is nonsense, exposes so many vulnerable points that I am tempted to pursue this wretched young man to utter extinction, but space is valuable, so I will overlook many "bald statements" about the "poorest and most thriftless of the community," and content myself with a comment on the last few lines.

If it is true that "numerical superiority alone will be useless" in the struggles of the races, why is it that history is full of instances of barbaric hordes overcoming the more scientific, but less numerous, resistance of an effete civilisation?

Finally, "S.," quite irrelevantly I venture to think, introduces Socialism, and openly attacks it without taking cover behind a reader of the *Daily Mail* or *Times*.

In the same breath, however, he goes on to say that working men must agree that "the future will recognise no one who does not earn his right to live"—certainly, but this sounds very much like something from the "pernicious will-o'-the wisp!"

However, in that sentence my critic gives the death-blow to his case, and answers every objection he has raised in his attack on racial morality, for surely the only ultimate test that can be applied to decide whether a man has earned his right to live is—has he passed on his life to others?

In conclusion, may I point out that I never suggested that the middle classes should increase their numbers to combat the wastrels of this life (whether these wastrels are drawn from the ranks of the idle rich or the degraded poor,) rather than let their increase swell the ranks of those who seek to give to all security and reasonable work and a tolerable life.—S.W.]

From the Gazette's Special Pathologist.

NOTICE.

Diphtheria specimens are to be labelled *Immediate*.

Specimens, Letters, and Postal Orders should be addressed to the MANAGER, Gazette Office, Guy's Hospital.

D., BROAD CLYST.—This specimen is comparatively non-purulent in character, and no tubercle bacilli are seen to be present.

PATHOLOGIST.

A Nursing Home Novel.*

On the strength of the *Spectator's* opinion that "Scotsmen, doctors, and nurses will welcome 'The Heart of Marylebone,' and with good cause," and that "the book deserves to be crowned by the medical profession," we read it. The story is that of a marriage hastily arranged and carried out just before the bride's departure to a nursing home where she is to undergo an operation. In the nursing home she becomes acquainted with the Heart of Marylebone, and also with a delightful Scotch doctor, and with several splendid nurses. The man she has married is out of touch with the Heart of Marylebone—is conventional, unimaginative, and dull; the husband and wife meet on no common ground. He is an icicle. The rest of the book is occupied with his thawing, his education in the secrets of the heart by the wife, who has the Celtic temperament, and knows them by intuition. The change that is wrought in him is a little incredible; one feels that not even marriage with a Leila Gaythorne could work so profound an alteration in such unpromising material. For education in such a man implies as much unlearning as development. And, at the outset, we can scarcely believe that such a conventional man could take part in such an unconventional wedding.

"Handasyde" has attempted three tremendous tasks, any one of which might have taxed powers greater than hers (if we are right in supposing the author to be a woman). She has attempted a comparative psychology of the Celt and Saxon, a task which even a Meredith left unfinished. And "Handasyde's" attempt seems only to lead to the discovery that the Celt is all "soul," and that no other race has any soul to speak of. The Saxon is, to put it vulgarly, "nowhere." Thus: "No one (*i.e.*, except the Celt) can love so much; no one else knows what love means. . . . All the inner finenesses of life belong to the Celt. . . . They always understand, it may be men and matters, or it may be women and whims. Englishmen only understand riches and cricket, and perhaps motor-cars."

Then "Handasyde" has attempted a psychology of the invalid, an equally difficult task. Everyone knows that in illness the whole mental outlook of a patient may become altered, and his attitude towards others as well as towards himself may be profoundly affected as a result of that introspection for which he has such peculiar advantages.

And, again, "Handasyde" has attempted a task suggested by a remark of one of her characters:—"I often wish I could write a book about all the things doctors do. No one knows one half, and lots of people would say it wasn't true." Here "Handasyde" has been more successful. The average book about doctors fails by making them either caricatures in sentimentality or caricatures in callousness. So, too, are nurses in books generally made either impossible fiends or angels. The nurses in this book, on the other hand, really live. And we find here a sympathetically drawn picture of a Scotch doctor, who combines all the superlative qualities of the Celt with the most noble traits of his profession. He is, perhaps, a little too given to sentimentalising to suit a mere Saxon taste, but, indeed, an excess of sentiment is the chief flaw we have to find in "The Heart of Marylebone." With this excess of sentiment is its usual accompaniment—a serious absence of humour. Henry Palmerston, the husband, is completely devoid of a sense of humour, and his spirit in that respect seems, unhappily, to have pervaded the book. We could not discover a trace of a joke until page 122, and then it is only a jest on the time-honoured subject of a Scotsman's caution.

On the whole, the book is well written, but the author has an unpleasant fondness for such words as "flair" and "flaneur" which occur with irritating frequency. The author, too, is greatly addicted to quoting, and not always aptly, from a variety of sources, embracing both Holy Writ and the "Ballad of Reading Gaol." The book is so good in many ways, in spite of its defects, that one wonders why it is not better.

* "The Heart of Marylebone," by "Handasyde." (Hutchinson & Co.) Price 6s.

Reviews, etc.

Books for review should be addressed to The Editor, Gazette Office, Guy's Hospital, S.E. Their price should in every case be stated.

Student's Handbook of Operative Surgery. W. I. de C. Wheeler. Second edition. (Ballière, Tindall & Cox.) Crown 8vo. 134 illustrations. Price, 7s. 6d. net.

This book, which has been thoroughly revised and brought up to date, forms an excellent companion to the man reading for his finals. In spite of the wide range of subject, it treats of all the operative treatment which it is necessary for him to know, though perhaps one might wish that the sections on the Radical Cure of Femoral Hernia and on Perineal Prostatectomy had been a little amplified.

The diagrams are good, and the plates illustrating Collateral Circulations will be found of great assistance in reading the ligature of arteries.

The book is written in a readable style, is well printed and strongly bound, and may be safely recommended to any student.

Manual of Operative Surgery. Treves & Hutchinson Third edition. (Cassell & Co.) pp. 820. Vol. II. Price, 36s. net.

This volume has been completely revised and parts of of it largely rewritten, especially those chapters dealing with operations on the skull, brain, and mastoid antrum, and the subject of tendon suture and grafting. In its present form the book will doubtless retain the popularity it has enjoyed in spite of the many other claimants for favour.

It is unfortunate that a rather large number of misprints are to be found in the book, for these slight errors cause annoyance and distraction to many readers, and might easily have been avoided by a more careful proof reading.

The chapter devoted to "General considerations in connection with Amputation" is very clearly and concisely written, and includes some practical points which we do not remember seeing in other books.

The section devoted to operations on bones, and that on mammary carcinoma, are frankly disappointing. Here, as indeed throughout the book, there arises the suspicion that but little importance has been attached to the possible value of recent work. Thus, resection of the diaphysis of a bone is not mentioned, the old, barely tolerant, attitude towards plating fractures is adopted, and the line of spread of mammary carcinoma is treated of in a superficial and scanty manner.

In the treatment of wounds of the wrist involving tendons, the directions are :—"Any microscopic foreign bodies and lacerated tissues which are visibly dead are now removed." This sounds difficult!

The book falls rather between two stools. It is too lengthy for the ordinary M.B. or Conjoint man, while it is not sufficiently full and up to date for the higher examinations, or for a book of reference.

Forthcoming Publications.

The Child, a new monthly journal devoted to Child Welfare, will appear in the early autumn. Dr. T. N. Kelynack has undertaken the editorial oversight, and will be assisted by a thoroughly representative staff of medical, educational and philanthropic experts.

The journal will be suited to the requirements of all engaged in Child Study or working for the betterment of Child Life. The first number contains communications from The Bishop of Ripon, The Earl of Meath, the Right Hon. John Burns, M.P., Sir Lauder Brunton, Bart., M.D., Sir Edward Brabrook, C.B., V.P.S.A., Prof. J. S. Mackenzie, Litt.D., Sir George Kekewich, K.C.B., Prof. Patrick Geddes, Prof. H. Griesbach, Dr. A. Mathieu, Prof. J. A. Green, M.A., Prof. Schuyten, Mrs. Kanthack de Voss, Dr. Theo. Hyslop, Sir James Yoxall, M.A., M.P., Miss Temple Orme, LL.D., Rev. W. T. A. Barber, M.A., D.D., J. Lewis Paton, M.A., John Badley, M.A., Rev. Arthur E. Gregory, D.D., Dr. H. T. Ashby, Lee F. Hanmer, Montague Crackanthorpe, K. C., Dr. Bertram Thornton, and others. Such a list affords ample evidence of the authoritative character of this forthcoming journal. Leaders in all branches of Child Study in this and other lands are among the promised contributers.

The Child provides a much needed medium for co-ordination and co-operation. Parents, educationalists, philanthropic workers, as well as physicians, school doctors, and other students of child life, will find that all their special requirements are adequately met by it.

In order that *The Child* may serve all interests working for child betterment, the publishers are arranging to issue with each number a Directory of Schools and other educational establishments; also of societies dealing with all forms of child welfare, and of hospitals, orphanages and like institutions for children. Heads of schools and secretaries of hospitals for children, and similar public institutions should communicate at once with the publishers. The publishers are Messrs. John Bale, Sons and Danielsson, Ltd., 83-91, Great Titchfield Street, Oxford Street, London, W.

Deaths.

ENSOR.—On August 23rd, at No. 33, Windsor Place, Cardiff, Henry Collen Ensor, M.R.C.S., L.S.A., Ophthalmic Surgeon, aged 51 years.

HOLMAN.—On Thursday, August 18th, Sir Constantine Holman, M.D., of 26, Gloucester Place, Portman Square, in the 80th year of his age.

Ed.—A. N. C.

GUY'S HOSPITAL GAZETTE.

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Passim.

TO enter upon the study of the great sciences of Medicine and Surgery might seem to the uninitiated to be a pretty serious affair, to be attended, therefore, with some ceremonial out of the ordinary, an occasion for Latin speeches, laying on of hands, and special raiment. Our artist has imagined the novitiate welcomed by Hygeia and Æsculapius, who have stepped for the nonce from their perches over the hospital entrance. But to the new student we would say, Do not be alarmed: nothing so embarrassing really happens. The signing of a few pieces of paper, in fact, makes you a Guy's man. There is no difficulty about taking the fatal plunge. "Fatal!" you say, "to become a Guy's man! This is strange talk!" Fatal only in this sense: that when you have once become a Guy's man you remain a Guy's man for the rest of your days.

We live in an age in which ceremony and symbolism are dispensed with wherever possible. During the last few years a change has taken place in the manner of opening the winter session at many of the London medical schools. It was formerly the custom for some man distinguished in or out of the profession to address the new students, to welcome them into the fold, so to speak, and exhort them to industry and the other qualities which are generally considered desirable. This custom, although it certainly had its good points, was never much in favour at Guy's, and now seems to be gradually dying a natural death elsewhere.

But do not think you are being neglected. The Medical Press has taken up the solemn duty of addressing you on the aims and ideals of the calling you have chosen. You will find in the special students' numbers of the *Lancet* and the *British Medical Journal*, in addition to a mass of useful information about examining bodies, scholarships, and the like, some advice on the spirit in which you should enter the profession, and the qualities of heart and mind which you should cultivate. In the *British Medical Journal*, also, you will find a somewhat dispiriting article on the prospects of medicine as a means of gaining a livelihood, which you may read as a gentle corrective to worldly ambition, and then forget until you are qualified and have started practice. Another paper which devotes a special educational issue to the needs of the new student is *The Hospital*, and in its pages you will find several articles which will "well repay perusal," as the phrase runs.

The task of the GAZETTE is a humbler one. We are not concerned with the whole body of new medical students, but only with those of you who (wise in your generation—one is tempted to say) have entered Guy's. This number is intended to give for your benefit an account of the two sides of hospital life—work and play. It is your privilege to enter at once into both these spheres, and it is *our* privilege to meet you there.

Guy's is not the largest, nor is it the oldest, of the London hospitals, but it is sufficiently large to make it one of the finest fields for clinical study available, and it is sufficiently old to have a history to be proud of, filled as it is with distinguished names and fine achievements. But the hospital cannot afford to rest upon its laurels; the greatness of the past may make us humble when we think of the present, but it should make us ambitious when we think of the future. Contemplation of the past is a worse than fruitless pursuit if, instead of leading us to emulate the achievements of our elders and betters, it makes us sneer at their imperfections.

There are only two virtues which are of much importance in the hospital world, or indeed elsewhere, for they include in themselves a multitude of minor virtues. They are Keenness and Unselfishness, and they are not mutually exclusive, as some people seem to think. Without keenness nobody ever achieves anything, either in work or play. It is needed in the dissecting-room, in the wards, in the surgery, on the football field, even at committee meetings, and after all these it is needed more than ever in practice.

Unselfishness is the keynote of the hospital motto, and it, too, is needed both in work and in games, and it brings its own reward. It is not for everyone—is indeed only for the few—to make some valuable scientific discovery which brings renown to the hospital; nor, on the other hand, to win a closely-contested Cup-tie for the hospital. But it is possible for everyone to work in a small way for the good of the hospital, and not entirely for personal ends, and in this matter we should do well to follow the example of some of our great predecessors whose love for the hospital was both the inspiration and the reward of their labours.

You yawn! And not without reason. To our well-meant advice you have the retort: "Why not practise what you preach?" or even one stage further—"Why preach at all?" Every October a band of new students enters the hospital, bringing new enthusiasm and new talents into our midst; is it likely that you bring none? On the contrary, is it not likely that there are among you a great surgeon of the future, and a distinguished physician, perhaps, possibly a scientist or two, some capable medical officers for the Army and Navy and the State services, and in all probability many astute and successful men who in the ranks of general practice will uphold the honourable name of Guy's Hospital among the generation that will regard you as its representatives.

THE Physical Society is adopting a new plan this year for the opening of its session, and in place of the dinner and address which have been held in former years, is giving a conversazione in the Medical School Buildings. This function is to be held on Friday, October 7th, at 8.30 p.m. The Society's honoured President, Sir Samuel Wilks, hopes to be present to receive the guests, and several of the Vice-Presidents also will probably attend. In addition to the usual display of books and instruments, there will be exhibits and demonstrations of scientific interest, while the lighter side of the entertainment will be provided, we understand, by music and refreshments. Invitations will be sent out to all new students, and also to old Guy's men, who will welcome this opportunity of social intercourse with old friends at this meeting.

ANOTHER opportunity to new students of entering at once into the social life of the hospital is afforded by the Rugby Football Club Ball, which is to be held at Prince's Galleries, Piccadilly, on Monday, October 24th, from 9.30 to 3. This promises to be a first-rate affair, and as there are likely to be many applications for tickets when it is too late, we recommend that, in order to avoid disappointment, application should be made as early as possible to the hon. secretary of the ball, Mr. J. G. Saner, the College, Guy's Hospital.

THE following appointments in the Dental Department have been made by the Treasurer upon the recommendation of the Dental Council: to be Assistant Dental House-Surgeons: Messrs. E. A. C. Knox-Davies, W. H. Wotton, and G. W. E. Holloway.

A Warning.

It has always seemed particularly unfortunate that by the nature of things a man who has chosen Medicine as his profession can have no knowledge of what his choice really means until some years after beginning his studies. Chemistry, Anatomy, Physiology, those are his early acquaintances, but they give him as faint a clue to what lies before as does the character of a servant to that of his master. Experience cannot be taught, nor would it be advisable to teach it if it could, but what can be done is to give the beginner some hint as to what lies before him, so that when he meets it it may not seem entirely strange.

A man starting on the study of Medicine has usually heard the rosy accounts of the successful, and the gloomy ones of the unsuccessful, has weighed up the pros and cons and has made his decision, or has had it made for him, on more or less reasonable grounds. There is, however, one aspect of the subject which usually escapes consideration, not because of its unimportance, but because it is an entirely personal matter, namely, the emotional effect of the study of Medicine. To the purely scientific mind there is no such effect, but we question whether Medicine is the proper sphere of such a one. A man of whom it can be said that

> "A primrose on the river's brim
> A yellow primrose was to him,
> And it was nothing more,"

belongs to the laboratory, and has no place by the bedside.

It is the human element in Medicine which appeals and at the same time repels As Dr. Hale White recently remarked, "Medicine is largely a matter of impressions, and a good clinician is the man who gets the right impressions," and in order to get impressions we must be ready to appraise the human element in a case as well as the signs and symptoms of which our science teaches us the meaning. Surely, one may say, nothing can be more attractive than the study of human nature, and such indeed is the case; but when one is brought constantly into contact with human nature under the most pitiful conditions, the study, while losing nothing of its attractiveness, possesses also a very painful side, and it is of this painful side that we would warn.

It is a side which presents itself more particularly to the man with whom Medicine is the centre of everything, and whose interests are focussed upon this one subject, and it of necessity makes him a bad doctor. A continued study of a morbid psychology must lead to abnormality in the student, and abnormality in this case means hypochondriasis.

An eminent politician, being remonstrated with for employing a particular physician, pleaded in reply "that Dr. —— was so ignorant of everything else that he could not be otherwise than profound in Medicine." There is no doubt that if a reputation is acquired by a physician for anything not strictly medical it may interfere with his professional progress, but this is confined mainly to those cases in which the *real* work of life has been neglected for the *ideal*, and does not apply to a healthy interest in things outside the strict professional curriculum.

That too close an adherence to Medicine can exist may seem questionable to the beginner, but that is because he has not yet encountered the fascinations of his future partner.

Medicine is by its nature a subject of interest to everyone, and there is a great tendency among laymen to take advantage of the presence of a doctor to discuss his subject with him *ad nauseam*, and this with other causes combines to prevent the young physician from leaving his work when he closes his book or leaves his patient.

So becomes ingrained upon him the habit of having his profession continually the centre of his interest, until all else seems of no importance. It is in such a man that the emotional side of Medicine becomes a danger, leading to the ruin both of his prospects in the profession and of his health, and therefore we would warn him to keep a curb upon his temperament from the start. Sympathy in a doctor is good, nay essential, but sympathy run riot is disastrous.

We cannot, perhaps, believe with Cowper, that

> "*God gives to every man*
> The virtue, temper, understanding, taste,
> That lifts him into life and lets him fall
> Just in the niche he was ordained to fill,"

but we can endeavour to mould our temperament to such a shape as shall be most fitting for the career we intend to follow, and it is with this intention that we would impress upon the young student the necessity of keeping his interests wide and of avoiding that fatal groove which is ever open to our footsteps, and from which, once entered, escape is so very difficult.

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

A further View of Race-Suicide.

DEAR SIR,—I agree entirely with the writer of the article on Race-Suicide, but would ask you to let me point out the biological aspect of this matter. The biological importance of better views than are at present in vogue does not rest on the sound moral grounds he has taken, but on a pitiless law of Nature. Huxley well said that Nature's method of punishment was not a word and a blow, not even a word, but a blow. This will be the measure dealt out to the "more successful," "higher," "upper," "richer," "better educated," or "better fed" classes (whichever adjective we choose to employ) if they indulge much longer in their present way of exhibiting themselves as unworthy to be perpetuated in succeeding generations. The biological point to which I refer is this—if selection is to have material from which to evolve a better race, it must have a very large range of variations from which to select the fittest to survive and prosper. In proportion as the offspring of the class of higher social value is limited, the fewer will be the favourable variations in the community. The variations arising from the lower and less successful masses will be vastly more numerous than those of the classes above them. The latter are putting their eggs in one basket in a grim fashion, and flaunting before an astonished world their own unfitness to rule. When England's rulers come to be chiefly recruited from the poor, ill-fed, less-educated but more fertile slum population, we shall indeed be in a dangerous condition.

As a medical man I own to a slight rising of my gorge when the typical only child—offspring of the "flat, motor-car and one-child pair"—is brought to me for advice, and yet from the pecuniary point of view he is a good client.—I am, yours, etc., M.D., Lond.

Some Practical Hints for Radiographers.

DEAR SIR,—I enclose a letter which has reached me from South Devon from a lady with whom I am *not* acquainted. The subject to which she refers is of great importance, and I am therefore anxious to place it before your readers.—I am, Sir, yours faithfully,

14, Weymouth St., Portland Place, W. ALFRED C. JORDAN.

Dear Sir,—In your work with the radiograph, has it occurred to you to use a sound wave on the mating which you put into your developing box, and find out whether to any such (possible the rather deaf) electric connection with light is negotiable, if for short we are going to call radium a light evolver. Again, would it, for further use for consumptives, be feasible to pass while working, a slight wave of terebene (lamb) mint or even peppermint fresh picked, this, for those who have been accidentally or purposely under drugs (to alter brain accelerations), which may possibly have altered the position of the brain, and so leave opening for larger air passings.

Then, for the lung lower portions (for I believe the highest to be in the brain), may I give you a wonderful idea of an old man who had in his younger days the rooted idea of like curing like, but had not lived in these days, of borrowing fusions of insanity for sanity. He believed that the "lights," as he called it, from a pig, for consumptives, would cure the "lights," as he called it, of a human, and it was a common and never-failing cure for the young children of consumptives, when they failed, to take the inner lining, called by *Devonshire butchers* the "kerchief," a piece of fine internal membrane, which is covered with tiny globules of very refined fat, "electrified" as they thought it, to shred it into the milk of its nearest older relation! but not its mother, when it formed with slow still warming an emulsion (pancrea). Then there was a special water-plant, which grew in a mill-race, and had to be cut with pure steel, worn on the person of the man herbalist, which was looked on as a certain cure for a later day consumption.

Is radium an ignit, without guile, as someone said, or may we look upon it as a pure light evoluting out of putrefaction? for we find it, strangely enough, where, after a *post-mortem*, disease was always stayed by being buried under such trees, and with such utensils as would form life enough to grow it into the tree, so that in after-time mother Nature might find a pure return out of her child's branches (trees) in fungi, which was called after the disease from which it grew, and for which it was an antidote. Could these vegetable—part animal, part mineral—*asmeas* be used in connection with your radiograph? It is a thought, if it is worth thinking of and working for, will you let somebody just send me a post card, for I am quite alone in my idea?—Yours faithfully,

To the Doctor,

Radiograph Laboratories, Guy's Hospital.

From the Gazette's Special Pathologist.

H. M., CLACTON-ON-SEA.—Smear preparations show many pus cells with a few blood discs and much cellular detritus associated with many micrococci and a few gram-negative bacilli. No tubercle bacilli are found. Media inoculated show colonies of a white staphylococcus and a coliform bacillus. PATHOLOGIST.

Dignus est intrare in nostro Corpore docto.
Initiation.

Lectures* for Sessions 1910—1911.

WINTER SESSION. OCTOBER—MARCH.

†	LECTURERS.		DAYS.					
Anatomy (1st & 2nd)	Mr. Steward and Mr. Fagge	9	—	Tu	W	Th	—	—
Microscopical Pathology (3rd) ...	Dr. Boycott, Dr. Eyre, Mr. Goodhart, and Mr. Catto.	2	—	—	W	Th(10)	—	—
Pathological Classes (3rd & 4th)	Dr. Fawcett and Mr. Rowlands ...	—	—		W(11.30)	Th(9.15)	Sat(11)	
Bacteriology (Jan. to Mar.) (4th)	Dr. Eyre and Mr. Catto	4	—	Tu	—	—	—	—
Practical Obstetrics (3rd & 4th)	Mr. Davies-Colley (Oct. and Jan.) ...	11.30	—	—	—	Th	—	—
Chemical Physiology (Jan.) (2nd)	Dr. Pembrey, Mr. Ryffel & Mr. Kennaway	11	—	—	—	—	Fri	Sat
Chemistry (1st and pre. sci.) ...	Dr. Wade	12.15	—	Tu	—	Th	—	—
Practical Chemistry	Dr. Wade, Mr. Ball and Mr. Merriman	10-12	—	Tu	—	Th	—	—
Advanced Practical Physiology (3rd)	Dr. Pembrey, Mr. Ryffel & Mr. Kennaway	11	M	—	W	—	—	—
Practical Medicine (3rd) ...	Dr. Cameron and Mr. Rippmann ...	—						
Experimental Physics (pre. sci.)	Dr. Fison	12	M	Tu (3)	—	—	—	—
Chemical Physics (1st)	Dr. Fison and Mr. Merriman	2	M	Tu	—	—	—	—
Practical Surgery (3rd)	Mr. Digby and Mr. Townrow	12.30	—	Tu	—	—	Fri	—
Physiology (2nd)	Dr. Pembrey (Oct.-Dec.)	10	M	—	W	—	—	Sat
Clinical Medicine (3rd & 4th) ...	*The Physicians*	4	—	—	—	Th	—	—
Surgery (3rd)	Mr. Symonds, Mr. Lane, Mr. Dunn and Sir Alfred Fripp.	9.30	M	—	—	—	Fri	—
Clinical Surgery (3rd & 4th) ...	The Surgeons	1.30	—	—	W	—	—	—
Elementary Biology (1st) ...	Mr. Assheton and Mr. Hughes	10.45	—	—	W	Th(2)	Fri	—
Morbid Anatomy (3rd & 4th) ...	Dr. Fawcett, Dr. French and Dr. Hertz	2	M	Tu	W	Th	Fri	Sat(12)
Medicine (3rd)	Dr. Hale White, Dr. Pitt, Sir C. Perry, and Dr. Shaw.	4	—	—	W (3)	—	Fri	—
Ophthalmic Surgery (Jan.) (4th)	Mr. Eason	4	—	—	W	—	—	—
Public Health (Jan.) (4th) ...	Dr. King Brown	4	M	—	—	—	Fri	—
Anæsthetics	Mr. Rowell (Dec.)	—						
Dental Surgery and Pathology...	Mr. Wynne Rouw	4	—	—	—	Th	—	—
Metallurgy	Dr. Wade	4	M	—	—	—	—	—
Practical Dental Metallurgy ...	Mr. Hopson (Jan.)	2.30	—	Tu	—	—	—	—
Dental Anatomy & Physiology...	Mr. Maggs	4.30	—	—	W	—	—	—
Dental Mechanics	Mr. Lewin Payne (Oct.–Dec.)	4	—	Tu	—	—	—	—
Practical Dental Mechanics ...	Mr. Pillin (Jan.)	2.30	—	—	—	—	Fri	—
Pathology	Dr. Boycott	12.30	—	—	—	Th	Fri	—

SUMMER SESSION. MAY—JULY.

†	LECTURERS.		DAYS.					
Medical Jurisprudence (3rd & 4th)	Dr. French and Mr. Ryffel	10	—	—	W	—	Fri	—
Midwifery (3rd)	Mr. Targett and Mr. Bellingham Smith	9	—	Tu	W	Th	Fri	—
Diseases of Women	Mr. Targett and Mr. Bellingham Smith	9	—	—	—	—	Fri	—
Mental Diseases (3rd)	Dr. Craig	9.30	M	—	—	—	—	—
Bacteriology (April to June) (4th)	Dr. Eyre and Mr. Catto	4	—	—	W	Th	—	—
Practical Obstetrics (3rd) ...	Mr. Davies-Colley	11.30	—	—	—	Th	—	—
Biology and Botany (pre. sci.) ...	Mr. Assheton and Mr. Hughes ...	2	—	—	—	Th	—	—
Physiology (2nd)	Dr. Pembrey	9.30	M	—	W	—	—	Sat
Histology (1st)	Dr. Pembrey, Mr. Ryffel & Mr. Kennaway	10.30	M	—	W	—	—	Sat
Practical Surgery (3rd)	Mr. Digby and Mr. Townrow	12.30	—	Tu	—	—	Fri	—
Practical Medicine (3rd) ...	Dr. Cameron and Mr. Rippmann ...	12	—	—	—	Th	—	—
Experimental Physics (pre. sci.)	Dr. Fison and Mr. Merriman	12	M	Tu (2)	—	—	—	—
Clinical Medicine (3rd & 4th) ...	The Assistant Physicians	1.30	—	—	W	—	—	—
Clinical Surgery (3rd & 4th) ...	The Assistant Surgeons	1.15	—	—	—	—	Fri	—
Morbid Anatomy (3rd & 4th) ...	Dr. Fawcett, Dr. French and Dr. Hertz	2	M	Tu	W	Th	Fri	Sat(12
Materia Medica (2nd)	Dr. Beddard	4	M	Tu	—	—	Fri	—
Anæsthetics	Mr. Rowell (June)	—						
Operative Dental Surgery ...	Mr. Parfitt	2	—	Tu	—	—	—	—
Chemistry	Dr. Wade	9.30	—	Tu	—	Th	—	—
Practical Chemistry	Dr. Wade, Mr. Ball and Mr. Merriman	10.30	—	Tu	—	Th	—	—
Exp. Pathology (Gordon Lectures)		12.30	—	—	—	—	Fri	...

* No effort has been made to include the many demonstrations or practical work.

† The numbers in this column refer to the years in which this course should be attended.

The Sciences.

Anatomy and the Dissecting Room.

How to begin Work.

A great many freshmen have already passed their preliminary examinations in Chemistry and Biology before they come up to Guy's. They are then ready to commence the study of two most important subjects—Anatomy and Physiology.

For the help of these new men, it is proposed to give such instructions as they may need in beginning the work of their first winter session at Guy's. It will be assumed that they have already decided what the general course of their study is to be; that is, briefly, whether they are going in for the First Medical Examination of the London University or not. Information on these matters is readily obtained at the Medical School Office, and any student who is not clear in his mind as to the examination he has to prepare for, should read carefully pages 95–98 in the "Green Book."

Under the Five Years' Regulations of the Conjoint Board, the first object of the student (entering, for instance, in October, 1909) is to pass the examinations in Chemistry and Biology, as failure to complete these by the following March (*i.e.*, 1910) must postpone the date at which the Second Conjoint should be passed (*i.e.*, April, 1911), so that students are advised, unless they have passed either one or both of the above subjects before entering the hospital, or are unusually well versed in the subjects for these examinations, to postpone dissecting until one or both (Chemistry and Biology) have been completed.

What follows refers, therefore, only to those who intend to undertake their dissections at once.

Saturday, October 1st.—There is no actual work done on this day, but each student who is ready to dissect (*vide supra*) should pay his fee for anatomical material in the Medical School Office, and then interview the Senior Demonstrator in the dissecting-room and see that his name is put down for a "part." He should then study the Red Book—which contains the rules of the dissecting-room—and purchase the necessary instruments and the other paraphernalia therein indicated. Any spare time is well spent in learning where the museums, class-rooms, and theatres are situated. The ground plan at the front of the "Green Book" will show them at a glance, and serve as a very efficient guide.

To find a "Part."

Look down the list of names on white cards which are suspended upon the wall of the dissecting-room opposite each subject or body. Be careful to take the proper side (right or left) which is allotted to you. If you fail to find your name on these cards, make yourself known and report the fact to one of the demonstrators present. The next thing is to obtain a bandage and cloth from the attendant (Hancock), who will be found in a room outside the dissecting-room. With these the "part" must be covered up at once to prevent the skin from drying. If the "part" is a limb, bandage it firmly from the hand or foot upwards as far as the bandage will go, and cover the remainder with a cloth, *but be careful to leave the metal ticket exposed to view. This ticket must on no account be removed.*

The Requisites for Dissection.

The following articles are essential, and must be purchased at once:—

a. Case of instruments. This should contain two or three good knives (preferably all-metal), two pairs of large forceps with a weak spring, one pair of strong pointed scissors, hooks, needle and blowpipe, and can be obtained from Hancock, the dissecting-room attendant, or at Messrs. Down Bros., of St. Thomas's Street; Messrs. Arnold & Sons, West Smithfield; Messrs. Maw, Son & Sons, Aldersgate Street; or Messrs. Allen & Hanbury, Plough Court, Lombard Street. Price about 15s. to 20s. Small or delicate instruments should, as a rule, not be procured.

b. Books. These are obtainable at Grattan's in the Borough High Street, next door to the post office. It is advisable to obtain *Cunningham's Practical Anatomy* (2 vols. 10s. 6d. each) for use in the dissecting-room, which shows how to proceed and what is met with in the course of dissection; *and* one at least of the standard text-books, viz., Gray, Cunningham, Morris, or Quain's Text Book. The inquirer will hear their merits compared at the introductory lecture and demonstration; if still in doubt he should consult personally one of the demonstrators, and take with him any old text-book he may possess for inspection and advice as to its use.

c. An apron and sleeves for the sake of protection and cleanliness. These are sold by Hancock. Any old coat may be worn under them. Instruments, books, apron and coat must be safely put away in a locker provided for the purpose; the key is obtained by making a deposit of 5s. at the Medical School Office. During the day hats and coats are kept at a special cloak-room under the Wills Library.

d. A disarticulated skull and a half skeleton. (*See below.*)

With regard to all the necessary articles mentioned above in a, b *and* d, *it is well to point out to new students that many men who have just completed their anatomical studies may wish to dispose of some of the above articles second-hand, and new students may obtain information about, and details of such things, to be bought from the Librarian or Hancock, with whom such things are usually lodged.* Before completing any such purchase it is always best to make sure that the books are of the last edition published, and that the instruments are reliable, points on which any of the demonstrators will gladly give advice.

How to Dissect.

The instructions given on this point in the text-books are by no means clear to anyone who is working in the dissecting room for the first time. He finds quite a new language in use, and no explanation of it in the margin. Thus, he is told to "make an incision," instead of "cut"; to "reflect the integument," for "turn back

the skin"; "anterior and posterior," instead of "in front and behind." Not a little of the difficulty and dulness attaching to anatomical description depends on the need of a mental translation of the language in which they are written.

To deal fully with the skilful act of dissection is unnecessary here, and we will merely give such short directions as are needful for the work of the first two or three days. The objects of dissection are—firstly, to educate the sense of touch, and to teach the hand and the eye to work together in delicate manipulation; and secondly, to enable the student to see and handle the different structures that he reads about in his books. The following advice may be given:—

1. Take your book (Cunningham) by which you intend to dissect and read over the pages giving directions for the skin incisions to be made in that particular part you are about to dissect.

2. Cut through the skin along the lines given in the books.

3. Turn back *the skin only*, leaving the fat upon the body. This is done by holding the knife obliquely with its edge towards the skin.

4. Take away the fat carefully without damaging the dense white layer which covers the muscles.

5. Clean the surface of the muscle. To do this make the muscle taut by moving the limb, or pulling on it with hooks; then with the point of the knife clear away everything covering the muscle by working *with* its grain or fibre, *not* across the fibres.

6. Before taking any fresh step in your own dissection get a notion of the arrangement of the parts you are going to expose, either from another man's part, or from the "pickle-room," or wax model museum preparations. *Most important of all, never remove any structure until you have obtained a good mental picture of it, and have also read in your book the description of it, and have satisfied yourself you know it.*

7. Work very slowly at first. To turn back the skin carefully is quite enough to occupy the first day's work-time.

8. Cover the "part" up with a cloth before leaving it for the night.

The student should, on the first day, ask one of the Demonstrators for a copy of the Red Book, which contains the rules of the dissecting-room, and also much useful information as to classes which must be attended, and particulars of the School examinations.

The first year's man will find that he has first of all to dissect an arm or a leg. Having found his part, he should next examine the notice board, where he will find particulars of the bone classes which are held twice a week by Mr. Hughes and Mr. Layton. He must attend the classes on the part he is dissecting, and at these he will find the anatomy of the bones and muscles he is dissecting fully explained.

OSTEOLOGY.

A thorough knowledge of the bones is the basis of anatomy, and hence the subject cannot be too carefully studied. The student will find that to know his bones well is of importance, not only in the School Elementary Anatomy Examination, but also for the Second Conjoint, Intermediate M.B., Primary F.R.C.S., and even for the Final Examination in Surgery.

Like other branches of anatomy, it must be learned practically—by handling the bone, reading the description of it, and noting the various marks upon it, each one of which has its meaning. In order that the bones may be studied at home as well as at the hospital, it is very important that each student should possess them. Half sets of bones, that is, the skeleton of one side of the body with the spine and head, can be obtained second-hand at a very moderate outlay, and if carefully used they will at the end of the course readily fetch half the original cost, or even more. Some very useful half-sets (second hand) are to be seen at Messrs. Millikin & Lawley's, 165, Strand, W.C., price 30s. If these are disposed of at the end of the Second Conjoint Examination for half the price, it follows that the immense advantage of having the bones always at hand while preparing for the examinations is obtainable at the expense of a few shillings.

In selecting a half-set of osteology it is as well to have some advice, which will be readily given by one of the demonstrators. See that the half-set is complete, and that each bone is of the *same* side. Avoid "the nice white bones," which dealers always charge extra for, and choose the rougher, better marked and dirtier ones. The preparation which makes them white does away with many of the marks and ridges which have to be studied. With regard to the disarticulated skulls, try the separate bones and see whether they fit into each other properly, as it is not uncommon to find skulls offered for sale, the bones of which have come from different subjects, and hence cannot be articulated.

It may be necessary to caution men against neglecting the subject during their first year: they will find the second year's work quite heavy enough as it is, and moreover may suffer the mortification of being spun in the school elementary anatomy examination at the end of the first winter session, if they neglect the bones in their first term's work.

DENTAL STUDENTS.

A dental student, on entry, must pay the fee (10s. 6d.) for material at the Medical School Office, between 10 a.m. and 1 p.m., so that a part may be allotted to him at the earliest opportunity. He should obtain a copy of the rules of the dissecting-room, and study those paragraphs which specially concern him. He should be careful not to miss the demonstration given by Mr. Thompson to first year's students, on Monday, October 4th, at 12 noon.

It is very important for first year's dental students to commence their anatomical studies without delay. During their first six months they should dissect the upper and lower extremities, and attend the bone classes held by Mr. Hughes and Mr. Layton throughout the winter and summer sessions. They should pass the elementary anatomy examination at the end of their first six months if possible, or failing this, not later than nine

months from their entry at the hospital. The subjects of this examination are:—

1. All the bones and ligaments.
2. The muscles and fasciæ of the upper and lower extremities.

The importance of having a thorough knowledge of the bones of the head and spine, with the muscles attached, cannot be over-estimated. Lack of such knowledge has caused the downfall of many at the final L.D.S. examination.

Having passed the elementary anatomy examination, dental students are allotted a head and neck, in which they are expected to dissect, besides the muscles and ligaments, the vessels, nerves, and other soft parts, and also to acquaint themselves with the anatomy of all the special regions of this part, *e.g.*, the orbit, mouth, pharynx, etc.

Special classes are held for these students, throughout the winter session, in the dissecting-room theatre, once a week, and a test examination is held on the work at the completion of the dissection and the course of demonstrations. It will be agreed that the second dissection is even more important than the first, and it is well to realise that, as the work done by each man is noted and marked every week by the demonstrator, and men are only signed up for the necessary session's work when these marks are satisfactory, careful and conscientious dissection, punctual attendance at demonstrations, and industrious reading up of all the work, must be begun as soon as the dental student enters the dissecting-room, and continued until the subject is mastered.

It is very essential that the study of anatomy, physiology, and surgery should be prosecuted energetically from the outset, thus obviating the necessity for "cramming" these subjects when preparing for the Final L.D.S. examination. Careful and patient dissection is the easiest way to learn Anatomy. An attempt to "cram" it from books is certain to result in disaster.

PHYSIOLOGY.

Physiology, which treats of the working of the healthy body, and forms, therefore, the institutes of medicine and the necessary foundation of any rational mode of treatment of the body in disease, differs from its sister subject, Anatomy, in that it requires much greater intellectual efforts for its acquisition, and a more thorough preliminary training for the comprehension of its doctrines. Physiology consists chiefly in the application of the natural laws elicited by the researches of physicists, chemists and biologists to the explanation and description of the phenomena occurring in the living body, so that an acquaintance with the chief laws of physics, chemistry and biology forms the necessary basis for the study of physiology. The study of the nervous system, moreover, requires some knowledge of psychology. The difficulty and importance of the subject would seem to indicate, in the clearest possible manner, the necessity of pursuing its study throughout the short space of two years which are devoted to the subjects that are preliminary to the work in the wards. On this account, the student beginning his medical studies in October must give all his energies to getting up his biology in order to pass in it at the earliest possible opportunity, and he may profitably combine with the biology lectures and classes the reading of some physiology, such as Huxley's *Elementary Lessons in Physiology*, or the smaller works on the same subject by B. Moore and by Foster and Shore. He is advised to attend the physiology lectures at this time, but cannot be "signed up" for them.

By the ordinary student the practical study of the subject included under the heading "Physiology" is begun in the first summer session. During the whole of this session he must attend the classes in Practical Histology. These are held in the students' histological class-room three times a week; each class lasts two hours. Students attending this course must provide themselves with a compound microscope, certain mounting materials (a list of which can be obtained at the office), and with Schäfer's *Essentials of Histology*, which should be carefully studied in the intervals between the classes.

At the end of the summer session an examination is held in histology. All students who have attended this class must enter for the examination. Only those who pass the examination will be allowed to attend the tutorial classes in physiology held during the second winter session in preparation for the examinations of the Conjoint Board. Those who fail at this examination will be examined in the following session.

During the first summer session and the first half of the second winter session, the student should attend regularly the lectures on physiology held three times a week, on Mondays, Wednesdays, and Saturdays. During the same time those who have passed the histology examination at the end of the previous session should attend the tutorial classes held by one of the demonstrators throughout the session. At the same time he should read up the subjects in some text-book such as Starling's *Elements of Human Physiology*, Halliburton's *Handbook of Physiology*, Stewart's *Manual of Physiology*, or Howell's *Text-book of Physiology*.

During the winter session, *i.e.*, from January to March, students must attend the classes in practical physiology, which are held on Friday and Saturday mornings from 11 to 1. While attending these classes, they are recommended to read up the subject in *Practical Physiology* (published by Arnold) which is used in the practical work.

Students who have been diligent in following this course of studies will be ready to enter for the second Conjoint examination at the end of this session. Shortly before this examination, a test examination is held by the demonstrators in order to judge of the fitness of the candidates. Those who fail to pass the Second Conjoint at this time must attend the revision classes held by the demonstrators during the two or three months preceding the July and January examinations of the Conjoint Board.

Certain modifications in this course of studies is necessary for those who are going up for the M.B. of London

or other Universities. Having passed their preliminary scientific before entering, they are free from the study of biology during their first winter session. They should therefore attend the physiological lectures and practical classes during this session. In their first summer they attend the histology classes, and read Schäfer's *Essentials of Histology*. During their second winter, they should attend the class in advanced practical physiology, which is held twice a week, each lesson occupying between two and three hours. This class should also be attended by candidates for the first F.R.C.S. examination, although in their case attendance may often be profitably postponed until the third winter session. The reading for this examination is similar to that required for the Second M.B. examination of London.

Those who are desirous of obtaining distinction at the Second M.B. examination should supplement the course of reading already indicated with original papers in the *Journal of Physiology*, with parts of Schäfer's *Textbook of Physiology, Recent Advances in Physiology and Biochemistry*, edited by L. Hill, *Further Advances in Physiology*, edited by L. Hill, and Leathes' *Problems in Animal Metabolism*. University students should also attend the advanced lectures given on Physiology for the London University.

Revision classes are held by the demonstrators during the two months preceding the first F.R.C.S. and M.B. examinations for the special preparation of candidates for these examinations.

BIOLOGY.

The course of instruction for the First Medical Examination for the London University M.B. Degree consists of lectures which are given on Wednesday and Friday at 10.45 a.m., and on Thursday at 2 p.m., and of demonstrations and practical work on Wednesday and Friday mornings 11.30 to 1.30, and on Thursday afternoons from 3 to 5 p.m. The course of lectures includes all the types required for the First Medical Examination, and a printed syllabus of these lectures is given out at the beginning of the session. The Biological Laboratory is open at all times between 8.30 a.m. and 5 p.m., so that students may revise their work and complete any part they may have been unable to finish in the regular hours. Those students who are preparing for the Biology examination of the Conjoint Board of the Royal College of Surgeons and Royal College of Physicians will attend certain of the above-mentioned lectures, which are specially noted in the above-mentioned syllabus. The practical class is held immediately after lecture in the Biological Laboratory. The requisite instruments, books, etc., for this course should not be purchased until after consultation with the lecturer, who will advise as to these in the first lecture. It is especially recommended that the purchase of a microscope should be postponed until after consultation with the lecturer, because a microscope has to serve throughout a student's career, and indeed afterwards as well, and it is important that an efficient instrument should be acquired in the first instance. R. A.

CHEMISTRY AND PHYSICS.

The student is sometimes tempted to regard Chemistry and Physics as mere preliminary studies, of little importance when once the respective examinations have been passed; and, unfortunately, he will find no lack of encouragement in this idea from those who, from lack of ability, or more often from lack of industry, have found these subjects irksome. But when it is reflected that vital activity is dependent on the incessant balancing of chemical changes of the most complex description, it cannot fail to be recognised how futile it is to attempt to understand the working of the human body, the greatest of living organisms, without a firm grasp of primary chemical and physical processes. Scarcely a step, indeed, can be taken in Physiology, Pharmacology, or Pathology without reference to chemical facts and methods; and, in addition to these practical applications, the exact habits of work and thought acquired in the chemical and physical laboratories are simply invaluable later in enabling the student to find his way through the morasses of ill-digested observation with which he will often be confronted.

The above principles are now fully recognised in the curriculum of the University of London, which should be carefully studied by every London student. This curriculum has been framed with the utmost care, with the object of leading students to their life work by the shortest and most direct route: first, through the pure sciences, carefully adapted to their future applications; next, through the applied sciences; and finally to clinical method. The matriculated student will, in his first year, study Inorganic Chemistry, Physics, and General Biology, and at the end of this period, provided he has worked diligently in the laboratories, and attended the lectures and revision classes regularly, should have no difficulty in passing the First Examination for Medical Degrees. In his second year he will study Organic and Applied Chemistry, together with Anatomy and Physiology, and at the end of the second winter, provided, as before, that he has worked steadily from the commencement, should have little difficulty in passing the First Part of the Second Examination for Medical Degrees. Anatomy, Physiology, and Pharmacology are then taken as the Second Part of this Examination, at the close of the third winter, prior to commencing clinical work in the wards.

From the Conjoint and the Dental student only six months' work is required, but those entering without previous knowledge of Chemistry and Physics will find that time hardly sufficient, and are usually advised to take the full "year" of three terms, or nine months.

But, whatever the ultimate aim of the student, his success at the examinations will depend very largely on the care and thoroughness with which he has done his laboratory work. Neither books nor lectures are in themselves enough; their use is to direct the student and help him to arrange and digest his knowledge. The more first-hand knowledge he acquires for himself in the laboratory, the more benefit he will acquire from reading, lectures, and revision classes. The last, indeed, as their

name implies, presuppose that the student has acquired a working knowledge of his subject, and are intended more to assist in the arrangement of ideas and clearing up of difficulties than in the acquisition of fresh knowledge. Guy's men have no excuse for neglecting laboratory work. The Chemical Laboratory, for example, is open every day from 9.30 a.m. to 5 p.m., and students are strongly urged to form early the habit of spending their spare hours, apart from those officially allotted, in one or other of the laboratories. Reading should be left for the evening. After a day in the laboratory, reading a good text-book will be found to give ample scope for thought, and rarely, indeed, be tedious. It is reading without practical experience that is so destructive of thought, and such reading is very properly stigmatised as "cram." "Cramming," or the memorising of words and phrases, without a knowledge of the corresponding realities, is one of the worst intellectual habits a student can acquire, and in the long run invariably leads to failure.

For the coming term, Chemistry Lectures start on Tuesday, October 4th, at 12.15 p.m. (Chemical Theatre); but before this students should go to the Chemical Laboratory (10 a.m.), to receive their locker keys and apparatus and commence practical work. Practical Organic and Applied Chemistry starts on Monday, October 3rd, at 2 p.m., and the Lectures on Wednesday, October 5th, at 11 a.m. Physics Lectures commence on Monday, October 3rd, at 12 (Physical Theatre).

PRACTICAL PHARMACY, MATERIA MEDICA, AND DISPENSING.

One of the many important things all medical students must know is how to write a prescription; it may even be necessary for the majority, when qualified, to know how to dispense the same, so that the student will do well not to neglect acquiring as much knowledge of this subject as he can.

The principles underlying the art of prescribing are comparatively few and are quite easy to grasp, especially to the man who remembers his chemistry, and has, in addition, some general idea of the chief physical properties of the substances commonly used in medicine. In addition, a considerable amount of purely memory work and application is required in studying the doses and preparations of the drugs in use.

The student is taught practically the methods of prescribing, he practises writing prescriptions for combinations of drugs with due regard to incompatibility, and he is taught how to dispense the prescriptions he has himself written.

The course covers the syllabus of the Practical Pharmacy of the Conjoint, the Intermediate M.B. Lond., and the Third M.B. Cantab.

During the year there may be three courses of three months each, should a sufficient number of students require instruction, which is given in the practical pharmacy class at the Dispensary by Mr. Finnemore, B.Sc. Lond., F.I.C., the Hospital Pharmacist.

THE MEDICAL WARDS.

Work in the medical wards is taken in two sections of three months each, with an interval of three months, during which time the post of assistant surgeon's dresser is held, together with that of assistant physician's clerk.

A few words of advice to the oncoming medical ward clerk may not be out of place. In the first place we would urge him most strongly *not* to take his "manual of medicine" and read it through from cover to cover. He should, however, endeavour to become thoroughly acquainted with those diseases of which he finds examples in the beds which have been allotted to him.

Secondly, he must become familiar with the various physical signs indicative of disease in the various organs of the body, comparing his own cases with others which he finds in the wards. Too often the keen and energetic clerk is so busily engaged in noting and learning signs of disease that he neglects to observe and remember appearances and landmarks which may be, or are, compatible with perfect health. We would advise him, therefore, to listen to the "normal" heart as well as to the diseased heart, to become accustomed to the normal vesicular murmur before he begins to grapple with the mysteries of "bronchial breathing."

Thirdly, we would strongly advise him to make a friend of his house-physician, from whom he will obtain many "tips" and "wrinkles" which will prove of immense value to him for all time, smoothing over rough places in the stony ways of medicine, and clearing up abstruse questions which have arisen as a result of his reading.

From his house-physician, also, the medical ward clerk will learn when a "tapping" will take place, when an urgent venesection will be required, or of the necessity for the surgeon's knife. In fact, if he be only willing and energetic, he will find the house-physician a complete "medicine-book" as well as a most kindly friend.

The arrangement for work in the medical wards is as follows:—The registrars are two in number; one is attached to the beds of Dr. Hale White and Dr. Shaw, the other to the beds of Dr. Pitt and Sir Cooper Perry. Each registrar makes a formal round four times in the week, and on the other two mornings he may be found in the clinical laboratory, or assisting at the more lengthy examinations in the wards. When the registrar visits any bed, the medical ward clerk responsible for the report of that bed MUST be present with rough notes of the history of the case, and he should, if possible, be able to describe the physical signs of disease. These rough notes, in the compiling of which the clerk should obtain the help of the clinical assistant, should subsequently be neatly copied into the report sheet, in order that the physician may inspect them upon his visit to the wards in the afternoon. After the visit of the physician, *the ward clerk should at once enter the remarks made by the physician*, and also the diagnosis, if the latter has been made. Only the physician's diagnosis is to be entered in the report.

The registrars begin their morning round at a quarter-past ten. The wards are open to the ward clerks until one o'clock, when they are closed for nursing purposes until half-past one. We mention this point because of late there has been some misunderstanding. The boards which are sometimes hung upon the doors of the wards at mid-day, indicate that the wards are closed to visitors.

In compiling his report, the ward clerk should be brief and thorough; he should avoid being "long-winded." He should pay attention to "family history," which may indicate a predisposition to disease, and he should make a careful summary of the previous illnesses from which the patient has suffered, consulting, if necessary, the records which are kept in the medical registrar's room.

Whenever possible, he should attend the post-mortem examinations which are held daily, and he should *always* be present at the autopsy of any case the record of which he has been keeping. The abstract of such autopsy is subsequently to be obtained from the post-mortem room and copied into the medical report.

With regard to books, we would recommend him to obtain Taylor's "Practice of Medicine," or Osler, and "Clinical Methods," Hutchinson and Rainy, or French's "Medical Laboratory Methods."

PATHOLOGY.

As soon as a student has passed his Second Conjoint or Intermediate M.B. examination, he should begin his study of pathology. Without a sound knowledge of this science it will be impossible for him to acquire any useful knowledge of either medicine or surgery. It is only by following out his cases to the bitter end when he is a medical ward-clerk, that he will see the anatomical changes produced by the diseases of which he has been learning the symptoms and the treatment in the wards. He will also begin to understand the snares and pitfalls that beset the path of the physician, and will often come back from the post-mortem room a sadder and a wiser man. He can, therefore, never be too emphatically urged to attend the autopsies on every one of his cases, and to spend as much time as possible in the post-mortem room. Autopsies are conducted every day of the week at 2 p.m. (Saturdays at noon), by Dr. Fawcett, Dr. French and Dr. Hertz, whose custom it is to draw the attention of the student to any changes that may be found. Again, a sound knowledge of surgical pathology will lighten the student's labours during his time in the surgical wards. It may well be said that no man can be a surgeon unless he is a good pathologist. He is expected to know the various forms of new growth and the relative frequency with which they occur, and the rapidity of their course in the different organs of the body. Having arrived at this diagnosis, he can remove the tumour and subject it to a microscopical examination, when his joy will be great at the accuracy of his diagnosis.

In order, then, to gain a useful knowledge of the naked-eye appearance of pathological conditions, he should spend as much time as possible in the post-mortem room, and also examine the excellent collection which is kept in the museum. Here the result of the autopsies and operations of many years are presented to him, but he should bear in mind that going round the museum cannot in any way replace the study of the fresh organs in the post-mortem room. During his term as post-mortem clerk the student should also make his hands thoroughly familiar with the proper methods of opening the body, removing the organs, examining and replacing them. This can only be done if he does the work himself as often as possible. He should also attend Dr. Fawcett's class on medical pathology and Mr. Rowlands' surgical pathology, which is held three times a week during the winter session. These classes consist of demonstrations on the naked-eye appearances of diseased organs, and are illustrated by specimens from the museum and the post-mortem room. They are held in the morning, and only last half an hour, so as to clash as little as possible with clinical work.

Equally important is a knowledge of microscopical pathology, where he will learn the essential nature of pathological changes. A class on this subject is given by Dr. Boycott and Dr. Eyre on Wednesday afternoons and Thursday mornings throughout the year. Bacteriology is taken in October to December and April to June, and morbid histology from January to March and July to September. The class must be attended during surgical ward clerking or the first three months of medical ward clerking, in order that he may acquire a good groundwork which he will be able to enlarge upon as he goes along.

In order to learn something of the principles which underlie pathology, the student should attend the lectures on general pathology. In May and October there are also informal classes adapted for the requirements of candidates for the first part of the Third M.B. Cantab., and the final M.B. of Oxford and London Universities.

There is no text-book that covers the whole field of pathology. New discoveries are continually being made. The best elementary manuals are Green's "Pathology" and Hewlett's "Pathology, General and Special." For general pathology read Adami's "General Pathology" and Lazarus-Barlow's "General or Experimental Pathology," and for morbid histology Woodhead's "Practical Pathology," of which the illustrations are very good. Many of the articles in Allbutt and Rolleston's "System of Medicine" should be consulted. For bacteriology Muir and Ritchie's "Manual of Bacteriology" is recommended.

BACTERIOLOGY.

The compulsory course in Bacteriology forms part of that in Microscopical Pathology, is held during the months of October, November, and December, and is repeated in April, May, and June. The course comprises short demonstrations, with especial reference to the life-history of the bacteria pathogenic to man, followed by practical instruction in the rudiments of bacteriology as applied to medical diagnosis. To this

end the members of the class study the methods of staining sputum, pus, and exudates to demonstrate bacteria; the methods of collecting morbid products for bacteriological investigation, and the estimation of such antibodies as agglutinins, opsonins, etc., in the body fluids; in fact, the technique pertaining to all the various examinations which can be undertaken in connection with the ward work. In addition, students are instructed in the practical details of media making, culture and staining methods, and they individually examine the more common pathogenic and non-pathogenic bacteria.

Consequently, Bacteriology should be regarded not as a compulsory subject of merely scientific interest, but as one which has an important and ever-present bearing upon diagnosis, and upon treatment. This course should therefore be taken as early as possible during the period of clinical study, if possible, when no ward appointments are being held.

Lectures on the bacteriology of special organs, and the recent development of bacteriological therapeutics (serum and vaccine treatments) and diagnosis, together with the various theories of immunity, etc., upon which these methods are based, are given weekly during January, February, and March.

THE SURGICAL WARDS.

In the surgical wards there is a division of labour, and corresponding to this division, the appointments fall into two classes—clerking and dressing. The student's first introduction to clinical work is as clerk in the surgical wards, and it is not unlikely that he may, on his first entry, be a trifle discouraged. The reasons for this are obvious. Entirely ignorant of surgery and even of the terms in common use, he is at once required to write full accounts of the cases admitted to the wards. He will find, however, that by paying attention to the advice we give him, his difficulties will be found to be anything but insurmountable.

Being the junior appointment in the hospital, there is a tendency in the minds of some, and a little more than a tendency in the minds of others, to belittle the post. That is unjust, and is the result of ignorance of the real functions of the surgical clerk. What the medical clerk is to the medical side, the surgical clerk is to the surgical side. The post is junior in point of time, but does not necessarily carry with it any stigma of inferiority. Their duties are identical: the preparation of the permanent hospital records of the cases admitted to the wards. What difference there is consists in this: the machinery of the medical side is less complicated than that on the surgical; whereas the whole of the work in the medical ward falls on the clerk, in the surgical wards it has been found advisable to specialise and to separate—for the sake of greater proficiency—the duties of clerking and dressing. This separation has thoroughly been justified by the results, the chief difficulty being the dependency of the clerk on the dresser for many details of importance. Dressers should, therefore remember that from them the hospital expects such assistance as will render the reports as complete as they can be made. On the clerk, however, rests the responsibility, and the excellence of his reports is a sure indication of smooth working and mutual assistance in the firm to which he belongs.

The most important point for a clerk to remember is that in after years cases and not book work will form his mainstay in practice, and that he cannot too soon get the clinical entity and results of treatment into his memory.

The appointment of an overseer to each firm of clerks in the person of a clinical assistant in the surgical wards is of inestimable value, primarily to the clerks, secondarily to the whole firm. The clinical assistant should be the immediate "ear" of all his clerks, to instruct them in their duties in the wards, also relieving the surgical registrar of many details in the filling in omissions of the reports of his firm.

We do not wish to exalt the clerk unduly, but to insist merely that in his work the same care and attention to detail, the same knowledge of human nature, are as necessary as in other appointments. Let him bear in mind that to him is given by the hospital the task of keeping its records. These are bound and kept, and by his work thus perpetually in evidence a man is judged. Bad reports are a lasting disgrace; good reports a lasting honour. The importance of good careful work by the clerks cannot be over-estimated. In the nature of things it cannot be perfect, but it must be as perfect as he can make it. By his first work in the wards he will be judged, and he will find that it is very hard to live down a bad clerkship. At the same time that he bears in mind the difficulties and responsibilities of his post, he should remember that he is a junior, and that any assistance he can lend his seniors should be offered ungrudgingly, and in return for this he will undoubtedly meet with that consolation and help in his work which is so necessary. There is no loss of dignity sustained in carrying screens to patients, or in the thousand and one small opportunities which present themselves of helping the other workers in the wards.

To the dressers we would submit that the performance of dressing is no part of the clerk's duty, and that it is no kindness to him to request him to undertake what he cannot from his position with good grace refuse, and what nevertheless he is unfitted to do.

The work of the firm, as a whole, should be the interest of each individual member of it. Pride should be taken not only in its splinting and dressing, but also in its reporting. A good house-surgeon and a good dresser will see that the reports are not below the level of those of other firms, for as they represent the work of the firm the individual members should see that they give a fair and accurate idea of that work. The clerk, aided by the clinical assistant, from this point of view is to be regarded as the mouthpiece of the firm to succeeding generations. The firm should see that he represents it fairly. It is essential that either the clerk should live within walking-home distance of the hospital, or else get a room

for the take-in week. All really good casualty work is done at night, and the periods for seeing the actual application of Croft's and Bavarian splints and treatment of fractures is all too short as it is.

As soon as he is appointed, he should obtain from the Medical School office the "Notes on Surgical Case-taking" issued by it. A few days before taking over the work he will meet the surgical registrar to find out to whom he is appointed, and should then learn from his predecessor what he can about the cases he is to take charge of, so that the work may be continued as nearly as possible without a break. At the present time there is an entire change of clerks every three months, but in the way indicated above, the break in the work may be obviated to some extent. He should learn quickly to take accurate pulse and respiration rates, and test urine, for without any exception the temperature, pulse and respiration rates, and condition of the urine must be included in the notes of every case on admission. The surgical registrar sees every new case with the clerk on the morning after admission, when he expects a history of every case to be ready. This, if vague, is useless. All symptoms should be set down in exact order, with the dates of their appearance. The exactness in detail is of the highest importance, and is a measure of the care with which the clerk has done his work. He should have a note-book, and should put down in it everything about the case that he can obtain from the surgeon, house-surgeon, clinical assistant, and dresser. This should be copied into the report as soon as possible. We would impress upon each clerk the value of seeing everything done by the dressers or house-surgeons—the operations, putting up fractures, especially when done at night in take-in week, and this should apply to manipulations on every case under the surgeon, and not only to the cases which the individual clerk has to report—as much may be learnt in this way which otherwise can only later be gathered with much greater effort.

He should also attend the practical surgery classes of the surgical registrar, who gives four courses a year, each beginning on the appointment of the new surgical ward clerks, and especially designed for their instruction in all matters relating to that appointment, and also the course of practical pathology which is then in progress.

Lists of the duties appertaining to each appointment are supplied to the students, and these are to be carefully followed out. The hospital not only expects this, but insists on it. We have laid stress so far on the appointment of surgical ward clerk, as it is the first post that the student holds, and because he is so often quite unaware of the objects of the appointment.

He will in time become a dresser, and will by that time have learnt the traditions that underlie his office. He should, before accepting office, have acquired most thoroughly the principles of aseptic surgery, and, on no account, ever depart from them subsequently. Let soap and water be his sheet anchor.

The surgical wards are visited every day by the surgeons and assistant surgeons at 1.45. Notice of operations, which usually take place on Mondays, Tuesdays, Thursdays and Fridays, except for emergencies, is posted overnight in the colonnade by the House-Surgeon for the week. The surgeons are assisted at the operations by the dressers, and the particular clerk to the case should remain close by throughout the whole operation.

Although we believe there is no rule which prevents freshmen attending operations and clinical demonstrations, we would point out that such a course of action is useless to them, and is not encouraged by the authorities.

Finally, we should like to repeat that although specialization has provided a clerk responsible for the drawing up of the hospital records, yet as this report is an account of the work performed by the firm as a whole, it touches the honour of every one in it that the report should be an accurate statement of the work done. The firm should be considered the entity, each separate member of which fulfils his own function, each at the same time being dependent on the others for the smooth, even working of the whole.

ANÆSTHETICS.

One of the most important of the appointments for senior students is that of Clerk to an Anæsthetist. The appointment is best held after that of full dresser, but it may sometimes be done concurrently with the latter appointment, provided that the day the anæsthetist attends does not clash with the days of attendance of the surgeon to whose firm the dresser belongs. The appointment, which is for one month, is now compulsory; that is, every man must have held it before he can present himself for his final examinations. Candidates for House Appointments are further required to attend a second course of instruction under one of the Honorary Anæsthetists, and to possess a certificate of proficiency. During his month of office the clerk attends one afternoon a week in the operating-rooms, either surgical or gynæcological, or at out-patients' when he administers anæsthetics under the supervision of the anæsthetist. He thus becomes acquainted with the various forms of apparatus, and gains practical experience in the administration of chloroform, ether, and A C E mixture. He also attends one morning a week at 9 a.m. in the dental department, where he has ample opportunities of learning how to give nitrous oxide, nitrous oxide and oxygen, and ethyl chloride for dental operations. Before holding the appointment the student should attend Mr. Rowell's course of lectures on anæsthetics, for though this is essentially a practical subject, it is very necessary to know something of the action of anæsthetics and the symptoms occurring during anæsthesia, and also to know what dangerous symptoms to look out for, and the treatment that should be adopted. When making application for the appointment, the clerk may be in doubt as to whether to apply for the out-patient department or for the theatre. Each has certain advantages. The clerk will probably give more anæsthetics at out-patients', but those given in the theatres are usually of much longer duration, and useful experience is gained in keeping patients for

some time in the stage of anæsthesia requisite for a prolonged operation. Hence there is but little to choose between the two.

The clerk should endeavour to watch the patient himself, and form his own opinion of the condition of the patient, and not be a mere machine for holding a mask at the direction of the anæsthetist. He should be careful to consider the feelings of the patient, especially when he is dealing with a nervous individual. Suddenly to place a charged A C E cone over a patient's face without a word of warning is to court difficulties, and even dangers, in the administration. He should remember that "burned faces," sore eyes, sore tongues, split lips and broken teeth are a reproach to an anæsthetist, and that if these accidents occur with private patients his reputation as an anæsthetist will be seriously damaged.

Lastly, it may be suggested that every man, after he is qualified, should take the opportunity of giving a few anæsthetics for emergency cases in the hospital in order to get accustomed to the responsibility of giving anæsthetics quite "on his own."

DAYS AND HOURS OF ATTENDANCE ON HOSPITAL PRACTICE.

Accidents and urgent cases of all kinds are admitted by the St. Thomas's Street entrance at any time of the day or night.

THE WARDS.

Medical Wards.—Dr. Hale White (2), Mondays, Tuesdays and Thursdays. Dr. Pitt (2), Mondays, Tuesdays and Fridays. Sir Cooper Perry (2), Mondays, Thursdays and Fridays. Dr. Shaw (2), Mondays, Tuesdays (10.30), Thursdays (10.30) and Fridays.

Surgical Wards.—Mr. Symonds (1.45), Mondays, Tuesdays, Thursdays and Fridays. Mr. Lane (2), Mondays, Tuesdays, Wednesdays, Thursdays and Fridays. Mr. Dunn (1.30), Mondays, Tuesdays, Wednesdays, Thursdays and Fridays. Sir Alfred Fripp (1.30), Tuesdays and Fridays. Operations (1.30) daily.

Obstetric Ward.—Mr. Targett (2), Mondays, Wednesdays and Thursdays. Mr. Bellingham Smith (2), Tuesdays and Fridays.

Ophthalmic.—Mr. Eason (2), Mondays and Thursdays. Mr. Ormond (2), Tuesdays and Fridays. Operations (2), Tuesdays and Thursdays.

THE OUT-PATIENT DEPARTMENT.

The days and hours of attendance in the Out-Patient Department of the hospital are as follows:—

Medical Cases.—Dr. Fawcett (1), Thursdays. Dr. Beddard (1), Wednesdays. Dr. French (1), Fridays. Dr. Hertz (1), Mondays.

Surgical Cases.—Mr. Steward (1), Mondays. Mr. Fagge (1), Wednesdays. Mr. Rowlands (1), Thursdays. Mr. Turner (1), Saturdays.

Obstetric.—Mr. Targett (1), Saturdays. Mr. Bellingham Smith (1), Thursdays.

Ophthalmic.—Mr. Eason (1), Tuesdays and Fridays. Mr. Ormond (1), Mondays and Wednesdays.

Dental.—The Dental Staff (9) every week-day.

Aural.—Mr. Mollison (1), Tuesdays and Thursdays.

Skin.—Sir Cooper Perry (1), Tuesdays.

Throat.—Mr. Steward (1), Fridays.

Electro-therapeutic.—Dr. Hertz (1.30), Wednesdays and Fridays.

Actino-Therapeutic.—Mr. Iredell (11), every week-day.

Orthopædic.—Mr. Rowlands (9), Tuesdays.

Nervous Diseases.—Dr. Hertz (9), Wednesdays.

DENTAL SCHOOL.

The dental student is supplied at the Medical Office with the Prospectus, Standing Orders, Notes on Probationary Work, List of Instruments, Calendar, and Clubs' Union Book.

These pamphlets should be carefully perused in order that acquaintance may be made with the general arrangements of the school and the scope of the work upon which the student will become engaged.

Instruments having been purchased at a dental depôt, the student should satisfy himself that he has been supplied with all of those described in the hospital list.

Probationary work upon the phantom head will occupy the freshman's time for about two months. This operative course, conducted by the staff demonstrators, is very comprehensive. It includes most of the conservative operations that the student will subsequently be called upon to perform upon patients, namely, gold and other fillings, crowns, inlays, and the treatment of devitalized and septic teeth. These manipulations upon the dummy, when done in a thoroughly sound manner, form a capital ground-work in operative dentistry.

Pupils in Dental Mechanics are received at the hospital, and a systematized and graded course of instruction is carried out by a competent teacher.

The regulations of the Royal College of Surgeons of England require that students shall pass two professional examinations for the dental licence. At the first examination certificates must be produced, *inter alia*, of having been engaged in the practice of dental mechanics under a registered dental surgeon, or under the direction of the superintendent of the mechanical department of a recognised dental hospital, during a period of two years, and of having manufactured and adjusted six dentures and six crowns.

As this examination may be passed in the month of May, the work of the first winter session should be largely devoted to demonstrations, dental mechanics, and lectures.

Students in difficulties about their work and needing advice are invited to consult the Dean, or any member of the Staff, who will be pleased to do what they can to promote the interests of students. W. A. M.

The Choice of a Microscope.

One of the indispensable adjuncts to medical study in these days is the microscope. The growing tribute which Sir Samuel Wilks has paid to this instrument is by no means an extravagant one, when it is borne in mind how exceedingly helpful towards the acquisition of knowledge in almost all departments of science the microscope has been. To quote Sir Samuel's own words, "It has opened up a new world, and created a new science." Perhaps the student, when he comes to make his first acquaintance with these new fields which the microscope has enabled us to explore, will fervently curse the existence of an instrument which has added so much to his already crowded syllabus of work, but as he becomes more friendly and intimate with bacteriology, histology, and microscopical pathology, he will also become keenly attached to his microscope, so much so, in fact, that—as we hear on good authority—it stands very low on the list of pawnable things that medical students periodically carry under the shadow of the sign of the Medicis.

The choice of a microscope, then, is a serious matter, and we would impress on the new student the importance of exercising proper care and discrimination in his selection of a good instrument. The advice and help of his teachers are always available, and it would be well for him to consult them when he has some special make of instrument in mind. For physiological purposes "the microscope must have two objectives, a $\frac{2}{3}$ inch and a $\frac{1}{6}$ inch, a nosepiece and an indicator fitted to one of the eyepieces. . . . An inferior instrument is worse than useless, for it is esential that the student should buy an instrument which will be of some use to him in future years, when, as a practitioner of medicine, he desires to examine tumours, urinary sediments, sputum, etc., for purposes of diagnosis. Antiquated instruments, such as those sometimes handed down as an heirloom in a family of doctors, are practically useless." In the biology class the student will make his first acquaintance with the use of the microscope, and although here a comparatively simple instrument with a low power suffices for most purposes, he should bear in mind that in his next year, when he comes to study histology, a good compound microscope is indispensable, and that afterwards he will want a superior instrument, fitted with a condenser and an oil immersion lens, for bacteriological work. The ideal way, of course, would be to invest in a thoroughly reliable instrument, fully fitted; but such instruments are expensive, and where money is a consideration to be regarded, a better plan would be to buy a sound stand, by one of the recognised makers, to which the various necessary addenda, such as revolving stage, condenser, etc., can afterwards be fitted. At first the two objectives above stated will serve for all practical purposes; later, an oil or a water immersion becomes necessary, while a triple nosepiece is desirable as well.

There are many standard makers whose names are recognised guarantees for the excellence of the instruments they manufacture. Of foreign makers, Zeiss and Leitz are, perhaps, the best known, and if the student is fortunate enough to be able to invest in one of their better-class instruments, he need have no fear that he will afterwards regret his purchase. These instruments can be purchased at most shops where microscopes are sold, and the Zeiss Company possesses a London agency in Margaret Street, Regent Street, W.

In choosing a microscope, it is desirable that it shall be of such a class as will meet all the requirements of the student's course. This of necessity means a considerable initial expense. Where, however, causes prevail which prevent this being done, a microscope should be chosen to which additions can be made from time to time as necessities dictate.

W. Watson & Sons, of 313, High Holborn, W.C., whose fame for British microscopes is world-wide, make a speciality of constructing various parts of their instruments with interchangeable parts, and also offer high-class instruments with every mechanical convenience at very moderate prices.

For a student's microscope of proved reliability they recommend their "Praxis" model, which with 1-inch and $\frac{1}{6}$-inch objectives, eye-pieces, and case costs £6 10s., while their "Bactil" stand has been designed specially to suit the wants of the beginner, as well as those of the most advanced worker. It has mechanical movements to the stage, giving a range of two inches of traverse, a compound sub-stage, and is supplied complete with $\frac{2}{3}$-inch and $\frac{1}{6}$-inch objectives and mahogany case for £12. Abbe illuminator and $\frac{1}{12}$-inch oil immersion objective can be added, together with triple nose-piece and an extra eye-piece, for £7 7s. 6d., making the total cost £19 7s. 6d.

Naturally, the selection is not limited to the two models that are mentioned, but either of them will be found thoroughly efficient for hospital work.

Watson's $\frac{1}{6}$-inch is a renowned lens, not only on account of its fine performance, but from the fact that it has the great working distance of one millimetre, enabling thickly-covered objects to be examined without inconvenience.

Other good makers are Messrs. Swift, whose instruments are slightly lower in price; Messrs. Crouch, who supply several instruments suitable for students. From all these makers catalogues and specifications may be obtained on application. Messrs. Millikin and Lawley, of 165, Strand, W.C., list a good serviceable article in their "Stand A." model, which, fitted with mechanical stage and two objectives, and triple nosepiece, is priced at £7 6s., and to which a condenser can easily be fitted. All these instruments we have mentioned are thoroughly reliable, strongly and firmly made, and possess the usual fine and coarse screw adjustments.

For bacteriological and blood examinations the student will need an oil immersion. This can be got from any reputable maker. The Zeiss and Leitz oil immersions enjoy a world-wide reputation for excellence, although they are a trifle more expensive than those by English makers. Messrs. Watson and Son make a speciality of objectives, and their "Parachromatic series" is

specially suitable for students. Their $\frac{1}{6}$, priced at £1 10s., which is supplied with their instruments enumerated above, is a particularly fine lens, giving an exquisitely crisp definition, combined with a flat field and a good working distance. Their $\frac{1}{10}$ water immersion is listed at £4, while their $\frac{1}{12}$, a new lens specially intended for the bacteriological student, is listed at the same price. They also supply a $\frac{1}{16}$ oil immersion (magnifying up to 3200 diameters, with a holoscopic eyepiece) at £6. Mr. Baker supplies a sound, reliable $\frac{1}{12}$ at £5, and a $\frac{1}{16}$ oil immersion at £6. A Zeiss oil immersion costs £8, a Leitz, £5, and a Reichert also £5. With most of these a bottle of immersion oil is supplied.

If the student is unable to go to the expense of buying a new instrument, he can often obtain a good second-hand microscope at a comparatively cheap price, and in the same way an oil immersion lens may be bought. It is advisable, in buying a second-hand instrument, to obtain it on approval, and give it a thorough trial before completing the purchase. Sometimes a bargain may be picked up at a pawnshop, or a second-hand dealer's shop; but there are several firms which deal in second-hand microscopes, and the student cannot do better than give these a trial. Their instruments are generally in good order and well preserved; in many cases nearly new. Messrs. Millikin & Lawley have a large number of second-hand instruments and lenses in stock by all the recognised makers, which they list at prices much below those charged for new instruments.

For histological work, the student will find a slide box, or cabinet to contain his finished slides, desirable. These may be bought at any microscopical instrument makers, the nearest being Messrs. Stanley, whose place is close to London Bridge Station.

Instruments.

Both in the wards and in the dissecting-room and the physiological laboratory, the student will find that he needs several instruments. In the wards he will want a stethoscope, dressing instruments, tape measure, etc., and in his previous work a dissecting case is an absolute essential. The number and choice of his instruments depend to a large extent on himself. If he is sufficiently keen to think it necessary that he should possess a blood-count apparatus, pocket spectroscope, and a good ophthalmoscope, his outlay will of course be considerably in excess of what he would spend were he to rest content with possessing the absolutely indispensable only. But such outlay, we would venture to remind him, will not be money thrown away. In after years he will find the possession of these instruments not only a great help but a sound investment, provided he has invested in good instruments, which will stand the wear and tear of hospital practice. It is true all the wards possess a certain number of necessary instruments, lists of which are affixed to the cupboards where they are kept. But the advantage of possessing an instrument of one's own, independent of those that the hospital provides, is obvious. Personal possession means personal interest, and though familiarity may breed contempt, it has its advantages.

There are many instrument makers in London, the majority of whom make a point of catering for the new student. We would not advise anyone, however, to write for a catalogue of surgical instruments. These bulky volumes are so large, and contain so much, that the average student will find it a work of some difficulty to make his choice from amongst the many and various models submitted to him. Rather would we advise the new man to find out from his teachers what he needs for his work, to make a list of such instruments as he requires, and then to go to one or other maker whom he has selected, and choose his necessities from their stock.

We therefore merely give the addresses of some of the better known firms, along with a few particulars of the items they stock for students.

Messrs. Allen & Hanburys, Ltd., Plough Court, Lombard Street, E.C., a firm within easy walking distance of the hospital, have a large and varied selection of surgical and other instruments. Their dissecting cases range from 10s. 6d. upwards, and are excellent value at the prices listed. They supply a special binaural stethoscope with flexible metal tubing at 12s. 6d., and have a large selection of students' dressing cases, fitted and unfitted. This firm also manufactures various models of hypodermic syringes; ranging in price from 2s. 6d. to 8s. 6d., and lists all the usual blood-counting apparatus. Their instruments are of English manufacture, thoroughly sound and reliable, and satisfactory in every way. Messrs. S. Maw, Son & Sons, 7–12, Aldersgate Street, E.C., have an equally large stock open to inspection. They list a large number of useful stethoscopes ranging in price from 4s. 6d., to an improved pattern with finger rest, catalogued at 8s. 6d. They also supply dissecting cases, dressing cases, and have in stock every kind of apparatus the student may find useful or necessary. Their instruments are guaranteed of English manufacture, and are catalogued at comparatively moderate prices. Messrs. Arnold & Sons, of West Smithfield, and Giltspur Street, E.C., who are instrument makers to St. Bartholomew's Hospital, manufacture their own instruments, and have special lines in dissecting and dressing cases for students. They also supply excellent sets of bones, half skeletons being priced from £2 19s. 6d., and disarticulated skulls from £1 15s. These sets are specially selected and may be relied upon to be sound. This firm lists a patent stethoscope, the "Phonophore," which has obtained high praise from those who have used it. It is priced at 6s. 6d. single tubes, and at 12s. 6d. binaural model. Messrs. Down Bros., Ltd., whose address is 21 St. Thomas's Street, S.E. (just opposite the hospital gates), are the instrument makers to Guy's Hospital, and the instruments turned out in their factory are as excellent examples of their kind as one could wish for. The student would do well to give Messrs. Down a call and inspect their large and varied stock of dissecting cases, dressing cases, midwifery bags, and last, but not least, their overalls. An overall is a necessity for the ward clerk, and by far the majority of overalls in this

hospital have come from Down's. The firm supplies all apparatus necessary for work in the wards or in the laboratories, and all their material is of the best quality. The Holborn Surgical Instrument Company, Ltd., 26, Thavies Inn, Holborn Circus, E.C., have also a large stock of instruments, at comparatively cheap prices, while Messrs. Millikin and Lawley, Strand, London, W.C., have always on hand a large variety of new and second hand instruments and bones.

At all these firms the student may obtain blood-counting apparatus, opthalmoscopes, pocket spectroscopes and other desirable, if not absolutely indispensable, instruments. Messrs. Watson & Sons, of 313, High Holborn, and Mr. Baker, of 244, High Holborn, however, list special sets of blood-counting apparatus designed for students and clinical use, and in addition stock several sets of microscopical apparatus, including stains, etc. Messrs. Stanley, Station Approach, London Bridge, who are opticians to Guy's Hospital, have a large and extensive stock of microscopical apparatus, such as slides, specimen boxes, etc., and their shop is conveniently situated for those who cannot afford much time. Their articles are of excellent manufacture, and thoroughly satisfactory.

As in the case of microscopes, the student can often obtain second-hand instruments at a comparatively cheap price. Sets of bones discarded by those who have no longer any pressing need for them may often be picked up cheaply, and the student would do well to interview the dissecting-room attendant (or the commissionaire, who will usually be found in his den underneath the Medical School Buildings). From both second-hand scalpels, forceps, or complete dissecting cases may sometimes be obtained. In buying second-hand instruments the student should assure himself that the articles are sound and reliable; and any instrument decided upon should be tried and approved of before it is bought. If at all in doubt his demonstrators will always be ready and willing to help him in deciding whether to buy or leave them.

Books.

The student who wishes to obtain his books at once should not take the first he sees on any particular subject, but would be wise to consult his demonstrators first; the number of text-books is very large, and the choice is a difficult matter to the inexperienced. Roughly speaking, second-hand books are very seldom worth anyone's while to buy, chiefly because medical science is progressing so rapidly that new editions are constantly being published. Especially is this the case in Physiology, where a book may become quite out of date in many points in the space of a couple of years. The other sciences of the first and second years' study are scarcely less pronounced in this progress. Hence a student is strongly advised not to purchase his books for his second year's work until that year has commenced.

The number of publishers of books for medical students is great. Messrs. Churchill publish Taylor, Jacobson, Goodhart, Fagge, and many other well-known works. Messrs. Macmillan publish Allbutt, Foster, and a great number of first-year books; Messrs. Longmans, Green & Co. publish the famous Gray's Anatomy. Mr. H. K. Lewis, 136, Gower Street, publishes a number of medical books, and has also a medical circulating library which is valuable to students who wish to see all the latest books. Mr. Murray also publishes many well-known medical books, as also do Smith, Elder & Co.; Philip & Son; and Cassell & Co.

As we have mentioned, it is rarely that second-hand books will be required, but there are cases in which they are valuable. Mr. Chas. Sawyer, 29–31, New Oxford Street, W.C., has a long list of last editions at very moderate prices, and there are other second-hand booksellers.

All books can be obtained from Mr. H. H. Grattan, in Borough High Street, who is the "official bookseller" to the hospital. Many well-known books he can supply over the counter; any others desired he will have in an hour or two.

Papers by Guy's Men.

A. E. Boycott, M.D., B.Ch. Oxon., B.Sc.: Experiments on Soap Anæmia.—*The Lancet*, 10th September, 1910.

W. J. Burroughs, M.R.C.S., L.R.C.P. Lond.: A Case of Chronic Constipation Treated by Faradism of the Large Intestine.—*The Lancet*, 10th September, 1910.

R. A. Chisolm, M.B., B.Ch. Oxon., M.R.C.P. Lond.: The Blood in Malignant Disease.—*Ibid.*

J. H. Fortescue-Brickdale, M.D., B.Ch. Oxon.: The Comparative Therapeutic Values of the Organic and Inorganic Compounds of Certain Elementary Bodies.—*Ibid.*

F. E. Fremantle, M.B., M.Ch. Oxon., F.R.C.S. Eng.: The Influence of Part-time Medical Officer of Health upon the Public Health.—*Ibid*,

G. W. Goodhart, M.B., B.C. Cantab.: Chloroform Necrosis of the Liver.—*Ibid.*

J. F. Goodhart, M.D., LL.D. Aber., F.R.C.P. Lond.: Note on the Central Origin of some Cases of so-called Heart-block.—*Ibid.*

A. C. Jordan, M.D., B.C. Cantab.: Types of Phthisis from the Radiographer's Point of View.—*Ibid.*

Sir Henry Morris, M.B. Lond., F.R.C.S. Eng.: Some Points for Consideration in Relation to the Surgical Treatment of Renal Calculus (Illustrated).—*Practitioner*, September, 1910.

Major C. E. Pollock, R.A.M.C., and another: Notes on the Conveyance of Sick and Wounded by Rail, with Special Reference to Improvised Methods.

The German Campaign in South-West Africa.—*Journal of Royal Army Medical Corps*, September, 1910.

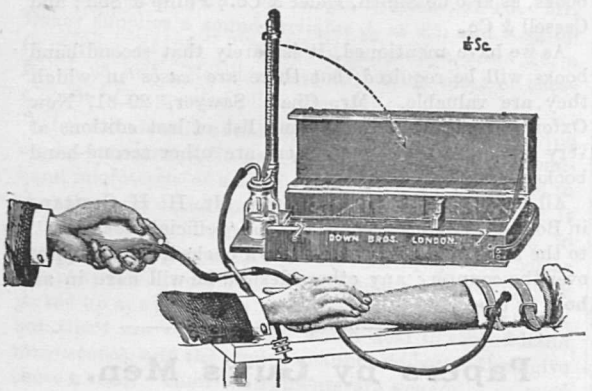
Cecil Price-Jones, M.B. Lond.: Alterations in the Size of the Red Blood Corpuscles.—*The Lancet*, September 10th, 1910.

Hubert J. Starling, M.D. Lond., D.P.H. Camb.: On the Value of Blood-pressure Determinations in the Toxæmia of Pregnancy.—*Ibid.*

Specialities.

A New Form of Sphygmomanometer.

Suggested by Dr. HERBERT FRENCH, Assistant Physician, Guy's Hospital.



This consists of a vertical mercury manometer connected, as shown in the diagram, with a four-way glass canula, the other three limbs of which lead to a rubber air-bellows, a broad rubber bag enclosed in canvas for encircling the arm, and a clip for letting out air when required. The principle is similar to that of various other sphygmomanometers devised for measuring the maximum systolic blood pressure. Most instruments of the kind, however, have the disadvantage that until fixed up they are not ready for immediate use, and that unless great care is used the mercury is very apt to become spilled, and that if the apparatus is carried to a consultation at a distance, much time is taken up in packing it so that nothing will go wrong with it *en route*. These disadvantages are obviated by this instrument. The box into which it fits has one of its narrow sides hinged, to which the mercury bottle is fixed in such a way that the whole manometer can either stand vertically, as in the illustration, or else be rotated down in the direction indicated by the dotted line and arrow until it lies flat in the box. The length of the glass manometer-tube and the amount of mercury in the bottle are so adjusted that whereas the lower end of the tube is immersed in the mercury when the manometer is vertical, the tube leaves the mercury some little time before it reaches the horizontal position. The result of this single adjustment is that the mercury cannot become upset whatever position the apparatus is in. It is something like the invertible inkwell in this respect. The great advantage of this is that as soon as a reading has been taken the manometer and its attachments can be laid down flat in the box, and the latter can be carried in any position—even upside down—without any spilling of the mercury. The apparatus can be carried amongst one's luggage, and yet on arrival it is ready for immediate use. When it is required, all that has to be done is to open the box, rotate the manometer into the vertical position, and take a reading in the ordinary way.

Owing to the hingeing of the mercury bottle to the main box, no clamp is required to prevent its upsetting.

There are minor points about the instrument, such as a contrivance for making the mercury in the manometer rise or fall smoothly, when blood pressure is being measured, without the wide jumpings and oscillations which are apt to occur in the case of some other forms of apparatus. As will be obvious, however, when the instrument is seen, the main advantage claimed for Dr. Herbert French's sphygmomanometer is that whilst giving direct readings in millimetres of mercury, it is so constructed as to be equally and instantly ready either for transit to a distance or for immediate use upon a patient.

The instrument is made by Down Bros., Ltd., St. Thomas's Street, London, S.E.

The "Watkin" Switch.

An advantage possessed by gas over electricity for lighting purposes has hitherto been that by means of the gas tap one is able to graduate the light to one's requirements, and at the same time prevent waste, whereas with the ordinary switches in use any such graduation of the electric light is impossible—the light is either "on" or "off," and there is no intermediate stage. Moreover, since the full light has to be switched on in cases where a dimmer illumination would be sufficient and more convenient, there is often considerable wastage by this method.

We have recently inspected the "Watkin" Switch, patented by the Adams Watkin Co., Ltd., of 36–38, Victoria Street, S.W., and it appears effectually to overcome this disadvantage of electric light as compared to gas. By means of seven stops connected with resistances made of a special material, seven degrees of illumination can be obtained, varying from the full strength down to a mere nightlight, the latter saving 80 per cent. of current. The use of the switch for hospital purposes is therefore obvious; by its means a subdued light can be had throughout the ward, without the trouble of putting in extra low-candle-power lamps for nightlights. It is also claimed that this switch effects a saving in the life of the filaments, especially of the delicate metallic filaments, since by its use the full current is sent through gradually, and not suddenly. Moreover, metallic filament lamps cannot be obtained for low-candle-power on a high voltage circuit.

The "Watkin" Switch can be used with any kind of current; it is readily fixed and requires no re-wiring, and it is durable and does not overheat. We consider that its introduction marks a distinct advance in the history of electric lighting. It can be used also, with a corresponding saving in current, for electric fans and motors, irons and cooking utensils, and for electrically-driven surgical and dental appliances.

On Perforation of Gastric and Duodenal Ulcers.

CLINICAL LECTURE BY MR. C. H. FAGGE.

GENTLEMEN,—Acute perforation of an ulcer of the stomach or duodenum is an abdominal emergency of the first gravity, and, in fact, it may be spoken of as one of the common abdominal emergencies. Moynihan writes, "This is one of the most serious and overwhelming catastrophes that can befall a human being." It is certainly serious in the suddenness of its onset, though not serious in entailing a large mortality, as I shall attempt to show. Moynihan* describes perforations of the stomach as acute, sub-acute, and chronic, the sub-acute variety differing only from the acute in degree rather than in type, and usually means that the perforation is a small one. The chronic variety is that which leaks for a short period, and then is, either by protective peritonitis or by a blockage of the opening with a particle of food, prevented from further leakage, so that the peritonitis is not a spreading or generalised one. So in the chronic form of perforation of the stomach, the gastric contents are localised by adhesions as they pass out of the stomach, and one of the varieties of perigastric abscess results; this is, of course, most likely to occur when the posterior surface of the stomach is the seat of the perforation: a similar condition results, though much less commonly from the chronic form of perforation of a duodenal ulcer. I shall say nothing about these abscesses, the results of chronic perforations, as it leads one into the very wide field of subphrenic abscess, of which I spoke this time last year.†

My series of 22 cases includes certainly one malignant case; and while speaking of this I would draw your attention to the difficulty there is, both during this and other gastric operations, in deciding whether an ulcer of the stomach is malignant or simple. Excluding the malignant case, ten of the patients were men, including one in which the perforating ulcer was in the duodenum, and eleven were women. Their ages ranged from 17 to 48; and of twelve cases of which I was able to look up the reports, five were over forty. You will therefore see that the statement which is made in so many books that perforation is a complication of acute ulcers in young women is probably untrue. Of these twelve cases, ten gave a history of pain after food, or of that vague abdominal pain which is described as dyspepsia: one gave a history of recurrent pain in the right iliac fossa which strongly suggested appendicitis: one had no previous symptoms of any sort. In several patients these symptoms had increased for ten to fourteen days before the sudden attack, and only one of these twelve cases gave a history of hæmatemesis. It is interesting to note—and I think it is the experience of others who have written on the subject—that the type of ulcer which causes hæmatemesis does not as a rule perforate; of this I can offer no explanation.

The characteristic thing about an acute perforation of a gastric or duodenal ulcer is the acuteness of its onset; acute, agonizing, sudden abdominal pain, associated with vomiting and a very variable degree of collapse: and it has been this sudden onset of pain which on many occasions of my series has determined an accurate diagnosis: so acute was the pain in several patients that they were reported as fainting. The initial position of the pain is important, because it is nearly always epigastric, and if it is not localised definitely to the stomach area, patients will certainly say their pain began above the umbilicus, as opposed to the other, even commoner, cause of acute peritonitis —you will at once recognize that I refer to appendicitis—in which the pain begins nearly always below the umbilicus. The pain in a peritoneal infection from perforative gastric ulcer gradually becomes generalised, and it is curious that in many cases it passes down to the left side of the abdomen towards the left iliac fossa: one woman who recently came into Clinical most definitely said that she had no pain above her umbilicus, but that her pain passed down into her left iliac fossa in such a position that one would have thought it was associated with disease of the left ureter. Sometimes this initial attack passes off; thus, in one of my cases the initial attack of pain was followed five days later by a more severe attack which no doubt indicated a perforation into the general peritoneal cavity. Speculating upon the earlier attack of pain in a case like this, one would assume it was due to a subacute perforation, in which the exit of gastric contents into the general peritoneal cavity had after a short time been stopped owing to the closure of the perforation by plastic lymph, only to be re-opened later and then giving rise to a general peritoneal infection.

The degree of collapse is extremely variable, and the following are some of the mechanical

* Abdominal Operations, p. 141.

† See Guy's Hospital Gazette, 1909, Vol. xxiii., p. 511.

or physical causes which influence it:—the size of the perforation is no doubt important, and so is the amount of food which escapes, and therefore the area of peritoneum which is involved. Again, it is true, as you would readily argue, that a perforation on the posterior surface of the stomach into the lesser sac of the peritoneum gives rise to less collapse than does perforation into the general peritoneal cavity from the anterior surface. But apart from this, there is an individual idiosyncrasy with regard to collapse; and it is important to realize this, for in a case which does not show any collapse you are most inclined to stay your hand and withhold the necessary operation. But of all the factors which influence the question of accurate diagnosis, the giving of opium is by far the most important, because it relieves the acute pain and obscures the condition of collapse, and I cannot too strongly impress this upon you as future practitioners of medicine. I have made it a general rule, in every case of acute abdominal disease which has been given opium, to advise no delay in opening the abdomen, and so far I have never been misled, and on the contrary have often found conditions much worse than could have been anticipated.

In many cases opium before an operation is imperatively called for to relieve the pain while the patient is being moved, or to tide over the interval during which arrangements can be made and a surgeon called in: provided a sufficiently definite diagnosis to demand operation has been previously arrived at, nothing but benefit to the patient can result, but if the surgeon is to be called upon to help in the diagnosis, then it often places him in a position of the greatest difficulty if the patient is deeply under the influence of this drug. Under such circumstances one must largely neglect the results of the physical examination and open the abdomen, because in so many cases the physical signs upon which you rely in an ordinary case of acute peritonitis are overcome by the opium.

A good example of this difficulty was an American girl aged twenty, who was always most injudicious in her diet, and whom I saw in private with Dr. W. Neale, of Hampstead. After a light supper at a dance, taken at 1.30 a.m., she was seized with some abdominal discomfort, which she referred to the lower end of her sternum; after this pain of moderate severity had lasted a few minutes it became excruciating, and she could only find relief from it by lying flat on her stomach on the floor. It was necessary to give her opium to take her home and obtain some measure of temporary relief. She was then seen by Dr. Neale, who found her pulse rate 96, and strongly suspected gastric perforation. We saw her together at 10 a.m., and there was no pain, the pulse was 108, the abdomen rather full and rigid, with some general tenderness. Bearing in mind the suspected perforation, operation was advised, and she was moved to a nursing home, but on again seeing her at 1 p.m. the abdomen seemed less rigid, and the pulse was only 104. I was then in doubt whether there was any general peritoneal infection, and operation was postponed, but four hours later, when no doubt the effect of the opium was passing off, her pulse had risen to 110, the abdomen was rather more rigid and full in its lower part. Exploration was decided upon and undertaken seventeen hours after the onset of symptoms. There was an ulcer which had perforated on the posterior surface of the stomach; there was no fluid in the general peritoneal cavity, though there was turbid fluid in her pelvis. The abdomen was closed without drainage, and she made an uninterrupted recovery. I alone was to blame for the delay, and was fortunate in that it did not entail a less happy result.

Moynihan, in writing of perforation of gastric or duodenal ulcer, points out that though opium stops the pain and slows the pulse, some degree of abdominal rigidity usually persists, so that in a case where there is any abdominal rigidity after opium has been given, I am certain that one may largely discount the absence of pain and the seeming general well-being of the patient, and can with confidence advise operation. In the early stage the feature of the greatest importance, to my mind, is a rising pulse; hourly, or even half-hourly, estimations of the pulse in a case in which one is in doubt, are of the greatest possible value, assuming, of course, that these estimations are taken under similar conditions, that is, with the patient lying in bed completely at rest. In the early stages, too, you find a subnormal temperature.

On abdominal examination, the chief physical sign which strikes one is abdominal rigidity. I have before my eye now the picture of a man who was brought into the front surgery in 1902, suffering from acute abdominal pain. Perspiration poured from him, the surface of his skin was quite cold and clammy; his pulse was 120, and his abdomen was generally rigid, and yet indrawn. He had the typical respiration of early general peritonitis, in which, owing to the irritation of the diaphragm, the respirations are short and jerky, and evidently each respiratory

act occasioned him an exacerbation of this acute abdominal discomfort. The above physical signs ought to be the only ones which we should ever see, for it is in this stage that the majority of diagnoses ought to be and will be made and operation undertaken. In the second stage—the stage, one may say, of reaction—one finds that the patient will often seem to be better, but it is associated not with a diminution in the pulse, but with an increased temperature and a rising pulse.

This insensibly passes into the third stage, in which the prognosis is much less favourable, and often hopeless. I am glad to say that now we see far fewer cases in this stage than when I was a student, fifteen years ago. Twelve to twenty-four hours after perforation the abdomen becomes uniformly rigid, is perhaps less generally tender than it was, but paralytic distension of the small intestine has begun, and one finds in a few hours the well-known board-like abdomen of advanced general peritonitis. This has often been described as an "acute belly," in which, before operating, one can say that there is general peritonitis, but cannot localise its cause. Thus in one of my early cases Dr. Shaw and I were inclined to regard the appendix as the cause of the general peritonitis, but at the operation I found it was due to perforation of a gastric ulcer. This was a typical late case, the ulcer having perforated forty-eight hours before the patient came into the hospital; and though the operation was followed by pneumonia he ultimately got well.

Next as to difficulties in diagnosis. I have already referred to what I regard as the greatest, but I make no apology for repeating it: it is opium. I of course agree that there is not the slightest harm in giving an abdominal case opium when it has been definitely decided that operation is required; but to give opium and then ask a man to come in and make a diagnosis, places the individual in a most awkward position. Having under such circumstances diagnosed the case, and then called in a surgeon, he simply comes in as a mechanic, and not as a scientific diagnostician. Such a position one is often called on and is willing to accept, provided the diagnosis has been made before one is sent for.

The second difficulty I have written down is, that after posterior perforations of the stomach, extravasation is limited. In the case of the American girl whose case I narrated, I have no doubt that the perforation occurring on the posterior aspect of the stomach was one of the factors which led to the delay in making an accurate diagnosis.

Passing for a moment to perforation of the duodenum, which throughout follows the same sequence of stages, you find that in the later stages of perforation duodenal ulcer tends to simulate appendicitis. The reason is that the fluid passing out of the duodenum, and the consequent peritoneal exudation, flow down into the right kidney pouch, in the region of the ascending colon, and then over the right posterior abdominal cushion into the right iliac fossa. So it comes about that some few hours after perforation, pain in duodenal ulcer is on the right—in sharp contrast to that of perforated gastric ulcer, which runs down on the left side—and in the former there may be a great deal of difficulty in making certain of a perforated duodenal ulcer after the first twelve or fourteen hours, unless you can get an accurate account of the initial localization of the pain. Moynihan pointed out this confusion in a paper* some years ago, in which he reported the results in forty-nine cases of perforated duodenal ulcer which had been recorded; and in eighteen of these cases the incision was made over the appendix.

With regard to other varieties of acute abdominal pain which will give rise to vomiting and collapse, there is a condition in the first few days of menstruation, of unknown pathology, which occasionally causes acute pain. These patients often vomit and become quite collapsed, and in several cases the abdomen has been opened. One might suppose it was associated with some hæmorrhage in the region of the ovary, though no physical condition has been found to account for the pain and collapse: this condition may be excluded by the absence of marked abdominal rigidity.

I have twice operated for supposed perforated gastric ulcer, and found the abdomen full of blood from a ruptured ectopic gestation. This is a difficulty which is likely to be met with occasionally, because both patients strongly denied any history which was likely to lead to an accurate diagnosis, the most important symptom being, of course, the missing of one or two periods. Usually this difficulty will not arise, for though acute peritonitis resulting from perforation of one of the hollow viscera gives rise to collapse and a certain amount of pallor, with cold clammy sweating, it does not lead to that acute condition of absolute bloodlessness about the face and extremities which is so characteristic a feature of severe cases of ruptured ectopic gestation.

* *Lancet*, December, 1901.

Lastly,* there is a condition which it is very difficult to exclude, namely, acute diaphragmatic pleurisy—difficult to us surgeons because, unskilled in auscultation of the chest, we have to rely upon the opinions of others. One so often finds one's self asking one's medical colleagues, Do you think there is anything in the chest to account for the abdominal pain? And it must be in the memory of some of you that cases of acute pneumonia, in which the superficial layers of the lung and the pleura are involved, have been operated upon on the supposition that the symptoms were due to a perforating gastric or duodenal ulcer. This is a condition which should never be out of one's mind in making a diagnosis of perforation of a hollow viscus.

Practically the only other condition which may give rise to some difficulty in diagnosis is the gastric crisis in locomotor ataxy. Though a very acute pain, this crisis is, as far as I know, never associated with collapse such as occurs in perforation of a hollow viscus. There are, in locomotor ataxy, absence of knee-jerk, the occurrence of the Argyll-Robertson pupil, and other signs to help one.

It is generally agreed that the incision should be a median one, extending upwards from the umbilicus to the xiphoid, and that it should be a free one. On carrying this out, at once the diagnosis is verified or negatived, because one, in most cases, immediately finds free gas in the peritoneal cavity, with some fluid, which is often turbid. Much of this fluid may have to be mopped away, simply because it mechanically interferes with the finding of the ulcer, but remember that the physical results of peritoneal infection are really curative, that the fluid is largely bactericidal, especially when it is clear: quite the opposite is true when the exudation is purulent, indicating that the virulence of the infection is overcoming the leucocytic output. So I think there can be no advantage to the patient in carefully and systematically removing any of the clear peritoneal exudation which is found in an early case: even more so does this apply to the protective lymph which one often finds matting the organs together. I remember the time when one-half to three-quarters of an hour was spent in carefully removing, with gauze and sponges, these areas of protective lymph: pathologically this has been shown to be wrong; clinically it has been shown to be unsuccessful, because most of the cases at that date died.

Sometimes during the operation you will experience difficulty in saying whether an ulcer is to the right or to the left of the pylorus, that is, whether it is gastric or duodenal, and it is for this reason that I have simply classed my cases together, because I do not mind confessing that I have paid very little attention to the position of the ulcer, for when it has been found my one desire has been to suture it up, and shut the abdomen rapidly. One of my cases which was, at the operation, presumably regarded as gastric ulcer, turned out, post-mortem, to be duodenal: probably in other cases a similar unimportant mistake was made.

Should the perforation not be found in the region of the pylorus, the posterior surface of the stomach must be explored by making a hole in the great omentum. In the case of the American girl, I was chiefly led to explore the posterior surface of her stomach because I found the great omentum was curiously œdematous, a condition I had never met with before, nor seen described. The fluid and gas which escape immediately the abdominal incision is made, if they are in any quantity, should at once tell you, by the absence of odour in the fluid, that it is not a perforation of any portion of the intestinal tract below the duodenum; which in itself tends to localise the perforation to the stomach, or to the first or second part of the duodenum; the presence of gas will, of course, usually indicate that there is a perforation of a hollow viscus.

In only one case have I failed to find a perforation, and in the report the Clinical notes that the patient died soon after being returned to bed, which explains why no exhaustive search was made for the ulcer, the patient being put back to bed after rapidly draining the peritoneal cavity.

There are various methods of suturing a perforated ulcer, and I will only make one or two remarks on the actual technique. I always use catgut, either putting a purse-string suture around the ulcer, or sewing it across from side to side. The position of the ulcer will determine what method one must use; because if it is near the pylorus one must use every means to avoid producing pyloric stenosis. Most surgeons now seem in favour of using some unabsorbable thread in the suturing of such peritoneal lesions, though as far as my experience goes, nothing has occurred to lead me to suppose that catgut is unsuitable. It is generally well to put a second layer of sutures

* See a most interesting paper by the late Mr. Harold Barnard, *Lancet*, August, 1902, on "the simulation of acute peritonitis by pleuro-pneumonic diseases."

outside the purse-string suture which bring a wider area of peritoneal together over the ulcer, and in placing both these layers of sutures there is one practical point of importance, and it is this:—the perforation is often of the size of the end of a penholder, and around it there is an area of œdematous induration which often has a diameter of two to three inches: it is of no use putting a suture into this œdematous area, because when you pass the needle through it, it cuts through, so that the whole of this indurated area must be invaginated with the perforation. This indurated circle is not made up of fibrous tissue from the organisation of inflammatory cells around a chronic ulcer, but is simply an acute recent inflammatory œdema of the gastric walls within that area.

I have already suggested that it is only necessary to remove freely as much as possible of the peritoneal exudation when its activity has been used up by long-continued war with the organisms in the peritoneal cavity. As a practical guide to help one to decide when this has been reached, it is wise to wash or mop out the exuded fluid as far as possible without injury to the peritoneum, in many cases where perforation has taken place more than twelve hours previously, in all cases of more than eighteen hours' duration. And under similar circumstances I think you should drain the peritoneal cavity by what is known as a cigarette drain, passed from above the pubes to the bottom of Douglas' pouch; in earlier, less virulent cases, where there is very little peritoneal exudation, drainage simply through a similar incision with a short tube passing only just inside the peritoneum is often sufficient. Personally, I do not find that there is any indication, from what I have seen myself, that local drainage in the epigastrium does any good at all, and in many early cases operated on within eighteen hours of perforation, even suprapubic drainage is unnecessary. Out of the twenty cases of which I know the result, twelve got well, and certainly six of them had no drainage at all.

Several of those which were drained by a tube passing down to the stomach died, but against this fact one must remember that drainage was only employed locally in the worst cases, which would be those likely to die. Beyond what I have said, I cannot express any definite opinion about this question, as my mental attitude is in process of transition, though I am sure that drainage above the pubes into the recto-vesical pouch is, in selected cases, a valuable addition to the suturing of the perforation. In one case, a girl of 17, who was recently in Clinical, and had perforated 6½ hours previous to operation, no peritoneal or other drainage was adopted, and about the end of the second week she had signs of an abscess in her recto-vesicle pouch, which was drained *per rectum* without any ill-effects: it is possible that one may, in such a case, avoid the formation of a pelvic abscess by a suprapubic drain.

In connection with the operation there are two other questions which are now exercising the minds of surgeons. One is easily dealt with, and it is, should one excise the perforating ulcer? I think the answer to this is, No, for two reasons. Firstly, because one knows well that ulcers of the stomach will heal marvellously: I mean this to apply to both acute and chronic ulcers. I believe that nearly all the cases I have operated upon were chronic ulcers, as I have seen nothing to make me believe in the perforation of an acute ulcer. And the second reason is that in so many patients suffering from gastric ulceration the ulcers are multiple. Apropos of this, the last case I operated on died, and Dr. French demonstrated in the post-mortem room the next day the presence of the perforated ulcer, of a healed ulcer, and of a recent ulcer on the anterior wall, "kissing" a contact ulcer on the posterior surface. It is obviously useless to excise a perforating ulcer if you leave others behind.

The next question is, should one, as Mr. Moynihan recommends, perform gastro-jejunostomy at the time of closing the perforation in all these cases? I cannot believe one should do an operation of convenience in a patient as acutely ill as many patients are with perforating gastric ulcers. If it is a condition which shows at least a mortality of 40 per cent.—a mortality which is largely due to immediate shock and peritoneal infection—you cannot expect to reduce the immediate risk to life, if you engage upon a proceeding such as gastro-jejunostomy, however skilful you may be. Personally, I think that what one might call moderate surgical opinion is in favour of the restriction of gastro-jejunostomy to the purpose of healing chronic ulcers. At the same time, the suturing of the ulcer near the pylorus may unavoidably lead to a definite pyloric stenosis, and in such cases gastro-jejunostomy must be carried out. I have only once been compelled to do gastro-jejunostomy after suturing a perforated ulcer, which was carried out a month after the original operation, on a man four years ago under Dr. Pitt, in whom persistent vomiting

after the ulcer was sutured, showed that he had marked pyloric stenosis.

Post operative treatment.—One would as a matter of course adopt the Fowler position after such an operation, the patient being propped up with pillows to an angle of 45°: it has been proved to be of the greatest possible value.

Beyond the question of the Fowler position in a simple early case, there seems to be no after-treatment required, except the free use of saline infusion, either *per rectum* or under the breast, as a prophylactic means against shock. In later cases post-operative shock is combated by the subcutaneous injection of pituitary extract, which seems to me the best means at present available; the hypodermic injection of strychnine for this purpose has generally been given up as ineffectual. Unless the bowels act naturally, or as a result of a soap enema given twelve hours after operation, I am strongly in favour of giving these patients some form of purgative within about thirty-six hours of operation. I have never seen anything which led me to suppose it did any harm, and as these people are those who suffer habitually from an inadequate evacuation of the intestinal contents, a good purgation thirty-six hours after the operation has, in my experience, led to only favourable results. For this purpose there is nothing like an ounce or one and a half ounces of castor oil; it relieves flatulent distension, and in my experience has never given rise to any troublesome diarrhœa afterwards; this complication has only occurred in patients in whom some loculus of pus has collected by gravitation in contact with the rectum or lower part of the large intestine. I am firmly convinced that diarrhœa coming on a week or ten days after such operations means that there is some abscess in contact with the rectum, which is irritating it.

Of my 22 cases, one was malignant; of one I cannot find the notes, as the volume of Hospital Reports was missing. I believe the patient got well and left the hospital. Of the other 20, eight died—three from shock and toxæmia within a few hours of operation, one on the fifth day—a phthisical man who died from bronchitis; two died from residual peritonitis, one died on the eighteenth day from a gastric fistula, which discharged through the external wound, and this case might be regarded as an argument against local drainage, for there was considerable and distressing excoriation of the surface from the gastric juice. One died on the forty-second day, after a second operation for intestinal obstruction due to kinking of the intestine from adhesions to the abdominal wall.

In 50 cases of gastric and duodenal ulcer reported by Crisp English, there was a mortality of 48 per cent. of the gastric and 75 per cent. of the duodenal cases.

It would be interesting to know what is the after-history of these patients, and what effect suturing has upon the ulcer. I have not much to say on this point which is of definite value, but in the case of the patient who died on the forty-second day, the post-mortem notes definitely state that there is a healed ulcer in the region of the pylorus; this was presumably the ulcer which had been sutured, as no other ulcer could be seen. In several of my cases which have remained under observation there has been no recurrence of gastric symptoms. Some of you may remember a man who was in Stephen Ward, under Dr. Pitt, in 1908. The case was diagnosed as malignant disease of the stomach, and after a consultation it was decided that, owing to the size of the mass, any curative operation was out of the question. After he had been in the ward three weeks he had symptoms suggestive of general peritonitis from perforation. I operated upon him five hours after the onset of acute symptoms, suturing the ulcer, and he did well, but continued to vomit, and the wound broke down. On the twelfth day I again opened the abdomen, and, finding the pylorus narrowed by the suturing of the ulcer, did a posterior gastro-jejunostomy, and to everybody's surprise he got well. I received a letter from him this morning, in which he says, "Since my return to business, in January, 1909, I may say my general health has been perfect. I can eat almost anything, nothing seems to disagree with me, and I am free from pain and discomfort, and feel quite able to attend my work as a clerk." He was certainly the worst case of perforation of gastric ulcer that I have ever seen get well; and it is interesting also, as I must candidly confess that, even after handling the pyloric tumour at the operation, I entirely agreed with the pre-operative diagnosis that the mass in the region of the pylorus was malignant. One of my earliest cases, a man, æt. 36, operated upon on September 1st, 1902, has since this lecture was delivered sent me his annual report, which he does, without fail, on each anniversary, saying he is well, without any symptoms of any kind. In this case, finding and suturing the ulcer was much hampered by an enlarged cirrhotic liver, and delirium tremens jeopardised his chance of recovery.

In the other cases I have had to operate on it seems—and I can offer no explanation of it—that the invagination of a perforating gastric ulcer leads to a process of cure. But it is a condition about which one can form no definite opinion, because one knows that these ulcers are often mutiple, and that there is a tendency in people who have had gastric ulcer to have a recurrence of symptoms which suggest recurrence of ulceration. But among those patients to whom I have written during the last few days, I have been unable to find that any have had any subsequent symptoms suggestive of persistent ulceration.

Nursing News.

Matron's Office.

Miss A. E. Jones, who has been Sister in charge of Stephen Ward since September, 1902, left the Hospital on August 27th, 1902, to go abroad. Since completing her three years' training in 1899, Miss Jones has held the posts of Night Sister and Sister in charge of the Surgery.

On July 30th, Probationer Traill was appointed Head Nurse in the Massage Department.

On August 1st, Probationer A. Du Sautoy was appointed Head Nurse in Lazarus Ward.

On August 3rd, Nurse Sladen, Head Nurse in Naaman Ward, left the Hospital on completion of her three years' training, and Probationer Shepherd was appointed to succeed her as Head Nurse.

On August 9th, Nurse May left the Hospital on completion of her three years' training, and Probationer Taylor was appointed to succeed her as Head Nurse in Bright Ward.

On August 10th, Nurse S. Lewis left the Hospital on completion of her three years' training, and Nurse Salmon was appointed to succeed her as Head Nurse in Addison Ward.

On August 11th, Probationer C. Prince was appointed Head Nurse in Addison Ward.

On August 11th, Nurse Marsh left the Hospital on completion of her three years' training, and Probationer McKenzie-Kennedy was appointed to succeed her as Head Nurse in Addison Ward.

On August 12th, Probationer Moriarty was appointed Head Nurse in Miriam Ward.

On August 16th, Nurse Sergeant, who completed her training in September, 1909, left the Hospital, and Probationer Jolliffe was appointed to succeed her as Head Nurse in Victoria Ward.

On August 18th, Nurse Aston left the Hospital on completion of her three years' training, and Probationer Roussiano was appointed to succeed her as Head Nurse in Lydia Ward.

On August 25th, Nurse Kenny left the Hospital on completion of her three years' training, and Probationer Holdsworth was appointed to succeed her as Head Nurse in Astley Cooper Ward.

On August 27th, Nurse Norman left the Hospital on completion of her three years' training, and Probationer Hinds was appointed to succeed her as Head Nurse in Esther Ward.

On September 1st, Nurse A. M. Ward, who has been acting as Staff Nurse in the Isolation Wards, left the Hospital.

On September 4th, Nurse Howe left the Hospital on completion of her three years' training, Nurse F. Ford, Head Nurse in the Surgery, was transferred to Dorcas Ward, and Probationer E. Foster was appointed Head Nurse in the Surgery.

On September 14th, Nurse Latcham left the Hospital on completion of her three years' training, and Probationer Bruce was appointed to succeed her as Head Nurse in Cornelius Ward.

Miss Nellis Thorpe, who completed her three years training in April, 1904, has been appointed Matron of the Cottage Hospital, Lewes. Since leaving Guy's, Miss Thorpe has held the posts of Night Superintendent and Day Sister at the York Road Lying-in Hospital, Night Superintendent at the General Hospital, Wolverhampton, and Matron of the Lancing College Sanatorium, Shoreham.

The following candidates from the Guy's Institution were successful in the last examination for the C.M.B. Certificate:—M. L. Bishop, M. Bouvier, L. E. Sergeant.

Appointments.

Civil.

KNAGGS, R. LAWFORD, M.D. Cantab., F.R.C.S. Eng., has been appointed Consulting Police Surgeon in Leeds.

WILBERFORCE SMITH, D., M.B., B.S. Lond., has been appointed Assistant Registrar at the Samaritan Free Hospital for Women, Marylebone Road, N.W.

Naval and Military.

Fleet Surgeon W. W. PRYN, R.N., has been appointed to the *Victory*, additional, for temporary service at Haslar Hospital.

Fleet Surgeon A. Gascoigne Wildey, R.N., to the *Pembroke*, additional, for Chatham Hospital, temporary, to date 1st October, and to Chatham Hospital, to date 18th October.

Colonel H. J. W. BARROW, A.M.S., has been placed on retired pay.

Lieutenant F. A. BARKER, M.B., I.M.S., is promoted to be Captain.

Guy's Hospital Clubs' Union

THE FORMATION OF THE CLUBS' UNION, by the amalgamation of the various constituent institutions, took place in the summer of 1891. The objects of the amalgamation are to further the interests of the clubs and societies existing at the hospital by their mutual support, and to simplify the collection of subscriptions. By the payment of an annual subscription (see Clubs' Union Blue Book, p. 13) to the Clubs' Union, any student of the hospital can obtain the privilege of membership of the constituent institutions.

THE GROUND OF THE CLUBS' UNION, which is under the control of the council, is situated close to Honor Oak Park Station, on the London, Brighton and South Coast Railway, and to the Crofton Park Station on the South Eastern and Chatham Railway. It is nine acres in extent, and is the headquarters of the Guy's Football, Cricket, Athletic and Lawn Tennis Clubs. Return tickets at single fare are issued by the Brighton Railway Company. Under such restrictions as are found necessary by the committees of the several clubs, and are approved by the council of the Clubs' Union, every member of the Union has opportunities of practising and taking part in matches, and in the various sports and games. There is a large pavilion upon the ground, with dressing and lavatory accommodation. Refreshments can be obtained by members of the Union according to the tariff of the Students' Club.

THE HOSPITAL "BLUE."—The "Blues" Committee, consisting of two representatives from each associated club, award "Blues" and "Half-Blues" to members of the following teams:—Rugby Football, Association Football, Cricket, Athletic, Lawn Tennis, Hockey, Gymnastics, and Water Polo, after considering the list of men suggested by the various Clubs' Committees through their delegates. Blues are awarded half-yearly, at the end of each session, so that the Rugby Football team be represented by fifteen Blues, the Association Football by eleven Blues, Cricket by eleven Blues, and Lawn Tennis by six Blues. Blues and Half-Blues are awarded for Athletics, dependent on the recommendation of the Athletic Committee according to the performances at the Inter-Hospital Sports, while there are allotted to the Water Polo Club seven Half-Blues.

CONSTITUENT INSTITUTIONS.

THE CRICKET CLUB.—President: Sir Alfred Fripp, K.C.V.O., C.B., M.S.: Captain: R. Montgomery; Hon. Sec. and Treasurer: F. C. Hunôt.

Matches are played throughout the summer session, fixtures being made for three XI.'s. There are both a Senior and Junior Inter-Hospital Cup. Guy's has won the Senior Cup sixteen times since its inauguration in 882. The Junior Cup has been in existence five seasons. Guy's has won it three times.

Guy's won both Senior and Junior Cups this year.

Practice matches are held early in May, and all freshmen should put their names on the list. Blues are given to the members of the Cup team, and Half-Blues to some members of the 2nd XI.

The Annual General Meeting will be held in March.

THE FOOTBALL CLUBS.—President: Frederick Taylor, Esq., M.D. Rugby—Captain: G. R. Hind; Hon. Sec.: C. S. L. Roberts. Captain 2nd XV.: G. B. Pritchard. Captain 3rd XV.: A. C. Hancock; Captain 4th XV.: E. A. Leviseur; and a committee of five, one representing each year. Association—Captain: A. H. Birks. Hon. Sec.: H. B. Neely. Captain 2nd XI.: W. Matthews. Captain 3rd XI.: W. H. Sutton; and a committee of five, one representing each year.

The Rugby Football Club has now been in existence for over sixty years. Very little is known of its early history. Among the many well-known players who at one time or another have played for Guy's may be mentioned the following International footballers:—A. W. Pearson, W. W. Pinching, A. H. Jackson, L. Stokes (Captain 1877–8), A. S. Taylor, W. G. Mitchell, A. Allport, H. W. Dudgeon, A. Alcock, H. Lee, H. Archer, G. R. Hind (England); H. H. Jordan, E. Morgan (Wales) R. Evans (Scotland); F. O. Stokes (Ireland).

The Inter-Hospital Challenge Cup was instituted in 1874, and Guy's had the honour of being the first holders. Since then Guy's has held the Cup thirteen times, St. Thomas's ten times, London five times, St. George's three times, St. Bartholomew's twice, and Middlesex and St. Mary's once each. In 1891, Guy's, Middlesex, and St. Thomas's were left in, the ties not being played out.

Last season Guy's retained the Cup for the second year running. In the first round we beat Charing Cross by 8 points to nil; in the second, University by 43 points to nil; in the semi-final, St. Thomas's by 22 points to 5; thus qualifying to meet London, whom we beat in the final by 8 points to 5. Our club record was also good.

The 2nd XV. again won the Cup, and with the 3rd XV. had a good season.

This year's fixture list is an improvement on last year's, and we expect to have a very good season, provided the right keenness is shown.

The grand stand has been much enlarged, and as we have most of our matches at home this year, we hope it will be well patronised.

It has been decided to try to run a 4th XV. this year; a few fixtures have been arranged. Trial games will be played in the first week of October. For the benefit of freshmen in particular, we may state that lists will be put up in the Smoke-room, on which intending players should write their names as soon as possible. The officers of the clubs will at all times be very glad to give any information in their power.

The Association Football Club "first saw the light" in 1882, and a high measure of success has rewarded its efforts from its earliest days. Four years later (1886) the

Inter-Hospital Challenge Cup (Senior) came into existence, and of the twenty-four occasions it has been competed for, Guy's has "been on top" no fewer than twelve times, St. Bart.'s being our nearest opponents with five wins. In its very palmiest days, Guy's also won the Surrey Senior Cup, viz., in 1887 and 1889. The Hospital Cup was won for the fifth time in succession by beating St. Bart.'s in the final, after having defeated King's and St. Thomas's in the earlier rounds. In 1898 the Inter-Hospital Junior "Soccer" Cup was competed for for the first time, and of the eleven finals we have won five. Last season the 2nd XI. reached the semi-final, but were most unlucky in losing to St. Thomas's.

And now another pleasing item—the revival of the 3rd XI., who had a very encouraging season indeed, and in no mean measure contributed towards the successes of the 2nd XI. May such keenness and happy results follow the club during the coming season!

Early in October trial games will be arranged to take place at Honor Oak, more especially for the benefit of "freshmen," and it is to be hoped that no freshman interested in Hospital "Soccer" will hesitate, *for any reason whatsoever*, to avail himself of this golden opportunity of proving his worth on the field, for it is largely on the result of these games that his subsequent inclusion in the team depends. Notices of such trial games will be posted in the Smoking-room of the College. A complete list of the season's fixtures will appear in our next issue. The club has entered for both the Surrey Senior and Junior Cups.

THE LAWN TENNIS CLUB.—*President*: W. Arbuthnot Lane, Esq., M.S.; Vice-President: J. Fawcett, Esq., M.D.; Captain: H. Sharpe; Hon. Sec., R. Curle, and a committee of six students.

The Lawn Tennis Club was founded in 1888. Two teams are run during the season, which starts on May 1st and finishes at the end of July. There are two Inter-Hospital Cups. This year we won both the Senior and the Junior Cups. A trial game is held early in the season, and tournament singles are played for the Arbuthnot Lane Cup during the season.

THE ATHLETIC CLUB.—President: J. Fawcett, Esq., M.D., F.R.C.P. Hon. Secs. and Treasurers: H. F. Renton and A. B. Danby, and a committee of eleven. The annual summer meeting is held in June, when the Lucas Challenge Cup is competed for, at the Clubs' Union ground. The team which represents Guy's in the Inter-Hospital Sports is chosen on the results of our sports. Blues and Half-Blues are awarded at the discretion of the committee. There is also a contest between the United Hospitals and Dublin University when possible.

In connection with the Athletic Club there is a Cross-Country Club, which has runs every Saturday, and races with the leading London clubs, and the Universities of Oxford, Cambridge and Dublin. Half-Blues are awarded in the Inter-Hospital Cross-Country race. Full particulars and notices of all club matters are to be found on the colonnade notice-board and in the smoke-room.

THE RIFLE ASSOCIATION.—President: Sir Alfred Fripp, M.S., C.B., K.C.V.O.; Vice-Presidents: G. Newton Pitt, Esq., M.D., L. A. Dunn, Esq., M.S., M. S. Pembrey, Esq., M.D., A. P. Beddard, Esq., M.D., R. P. Rowlands, Esq., M.S.; Capt.: G. A. Blake; Hon. Sec. and Treasurer: E. O. Yerbury; Committee: H. L. Attwater, W. Robinson, G. A. Blake, H. F. Hogben, E. O. Yerbury, and L. D. Wright.

This Association, which was founded in 1883, is a constituent unit of the Clubs' Union, and all members of the latter are, *ipso facto*, members of the former, without extra subscription. Any Guy's man not a member of the Clubs' Union can join the Association by an annual payment of five shillings. A Hospital Half-Blue is allowed to members of the team.

The Association is one of those forming the United Hospitals' Rifle Club, so that all Guy's men have the use of the United Hospitals' targets at Bisley, and can compete at the United Hospital Prize Meeting. There are now three Inter-Hospital Cups for teams—the Bisley, the Armitage, and the Lloyd—and one individual—the Arnold—which is competed for at the Annual Meeting.

There is an annual Guy's Hospital Prize Meeting, which includes a scratch handicap and aggregate competitions, five in all, the Scratch Challenge Cup presented by Dr. Pitt being the most important prize.

Vouchers entitling men to cheap return fares to Brookwood—the Station for Bisley Camp—are issued, and the London and Middlesex Counties' Rifle Association are kind enough to allow us the use of their hut on all hospital shooting days. The Association keeps a rifle which is available for the use of any man not possessing one of his own.

During the past year efforts have been made to start a Miniature Rifle Club in connection with the Association, but it has definitely been arranged that there is no place for one here or at Honor Oak Park.

All men who have ever done any shooting at School, University, etc., are asked to give their names and averages to the Hon. Sec., or to some member of the Committee, before next May. Several members of this year's team will be available for next season, and a good reserve of reliable shots is essential if we are to win back the Cups.

The Annual General Meeting will be held somewhere about the end of October, and it is hoped that all men interested in shooting will endeavour to attend. Notices as to date, time, and place, will be posted in the Smoking-room, and on the board in the colonnade.

THE GOLFING SOCIETY.—President: G. Newton Pitt, M.D. Vice-Presidents; H. C. Cameron, M.B., H. L. Eason, M.D., M.S., C. H. Fagge, M.S., F.R.C.S., J. Fawcett, M.D., A. W. Ormond, F.R.C.S., F. J. Steward, M.S., F.R.C.S., R. Davies-Colley, M.C.,

F.R.C.S., and E. C. Hughes, M.C., F.R.C.S. Committee: R. Creasy, R. Curle, F. Kahlenberg, W. S. Kidd, J. G. Saner, J. M. Jarvie. Hon. Secretary and Treasurer: F. D. Saner.

This society was formed in May, 1908, for the purpose of promoting Inter-Hospital Golf, and also to provide local interest by means of competitions, matches, etc. The society is affiliated to the Clubs' Union, and therefore all members of the Union are members of the society. Matches are arranged with other hospitals and clubs. A Monthly Medal Handicap Competition is held on the first Wednesday of each month. Cards and information can be obtained from the Secretary or any of the Committee.

An arrangement has been made by which members of the above society may play on five days in the week—viz., Monday to Friday—at the Ilford Golf Club, on payment of an annual subscription of £1 1s., without entrance fee. Such members may play on Saturdays, Sundays and Bank Holidays at the rate of 2s. 6d. a day.

We are indebted to the Committee of the West Essex Golf Club for the following arrangements:—Members of the Guy's Hospital Golfing Society may become five-day members of the West Essex Golf Club on payment of an annual subscription of two guineas, without entrance fee. Such members may play on Saturdays and Sundays on payment of a daily green fee of 2s. 6d. Members of the Society may play at West Essex any day, except Sunday, at a green fee of 2s. 6d. a day, On Sundays the green fee is 5s., unless accompanied by a member of the West Essex Club, when it remains at 2s. 6d. Club Competitions are now played at West Essex.

THE HOCKEY CLUB.—President: F. J. Steward, Esq., M.S., F.R.C.S. Vice-Presidents: A. W. Ormond, Esq., F.R.C.S., C. H. Fagge, Esq., M.S., F.R.C.S. Captain: G. Y. Thomson. Vice-Captain: L. Bromley. Hon. Sec. and Treasurer: F. A. Dick.

Negotiations have now been completed for the renting of a ground at Malden, Surrey, and a number of Wednesday and Saturday matches for 1st and 2nd teams have already been arranged. A few dates, however, are still vacant, and the Hon. Sec. will be glad to hear of any suitable teams for either Wednesday or Saturday fixtures.

In the Inter-Hospital Tournament, St. Thomas's was beaten 5 goals to 2, St. Bartholomew's 7-0, and in the final London succumbed by 3 goals to 6. Thus the competition for the fourth consecutive year, and for the fifth time out of the seven times that it has been in existence, was won by Guy's.

The team was the same as that which played the season before, but this year considerable improvement was shown, especially among the forward line, which was re-arranged.

The General Meeting has been provisionally arranged for Monday, October 3rd, and trial games for Wednesday and Saturday, Oct. 5th and 8th respectively, but due notice of these will be posted up in the Colonnade and the Smoking Room, and it is earnestly hoped that all freshmen and others, who desire to play this season, will attend. All communications should be made to G. Y. Thomson, L. Bromley, or F. A. Dick.

THE SWIMMING CLUB.—The Guy's Hospital Swimming Club was formed in 1892, under the presidency of Mr. A. D. Fripp. The Inter-hospital Water Polo Cup Competition was instituted in the same year, and Guy's have entered for the Cup every season since, winning the competition seven times, and halving it after three drawn matches, with St. Thomas's in 1905. Guy's have held the cup for the last four years in succession.

The following are the Officers of the Club:—President: Sir Alfred Fripp, K.C.V.O. Vice-Presidents: C. H. Fagge, Esq., M.S., R. P. Rowlands, Esq., M.S., F. S. Steward, Esq., M.S., J. Lewin Payne, Esq., L.D.S., Graham Marshall, Esq., L.D.S., and T. B. Layton, Esq., M.S. Captain of Water Polo: H. G. Rice. Captain of Swimming: A. V. Moberly. Hon. Secretary and Treasurer: M. Pern.

Besides the Cup Competition, there is an annual Inter-hospital Team Race. Last year Guy's were successful in winning both Cups. This year we were again successful in winning the Water Polo Cup, beating London in the semi-final and Bart.'s in the final by nine and eight goals respectively, but were unfortunate in losing the swimming race by a touch, London being the winners.

An entertainment is held every year in June, consisting of races, diving, costume race, etc., etc.

Students, by the courtesy of the Matron, are allowed to use the swimming bath in the Nurses' Home on alternate week-days and Sundays. Opportunities for practice, both at polo and racing, are thus abundant.

The Annual Meeting, which all freshmen interested in swimming should attend, will be held early in the new year. Notice will be given on the board in the Colonnade.

THE PUPILS' PHYSICAL SOCIETY.—Hon. President: Sir Samuel Wilks, Bart., M.D., LL.D., F.R.S. Hon. Vice-Presidents: J. F. Goodhart, M.D., LL.D.; F. W. Pavy, M.D., F.R.S.; Frederick Taylor, M.D.; G. H. Savage, M.D. Hon. Secretaries: C. H. Rippmann, M.D.; K. H. Digby, M.B., B.S.

This flourishing society was founded in 1830, on the plan of the old Physical Society, which existed during the latter part of the eighteenth century at Guy's Hospital.

At the Pupils' Physical Society, which meets each fortnight on alternate Wednesday and Saturday evenings, a paper on some subject, not necessarily of medical interest, may be read by any member, to be followed by a discussion. "Clinical" and "Pathological" Evenings are devoted to the exhibition and discussion of interesting cases or specimens which may be shown by any member. Members are reminded that in connection with the society the following prizes are offered for competition: The Treasurer's Prize of £5 is given annually; the subject of the Essay for this year is "Rheumatic Fever in the last decade." The society offers a prize of £10 for the best paper read during the session; a prize of £5

to the member who distinguishes himself most in the discussions; and a prize of £5 to the member who exhibits the best specimens of scientific interest during the session

THE DENTAL SOCIETY.—President: H. C. Malleson, Esq., M.R.C.S., L.R.C.P., L.D.S. Hon. Secretary and Treasurer: H. D. Shore.

The object of this Society, which was founded in 1894, is the promotion of interest in Dental subjects, and the discussion of Dental topics. Papers are read before the Society each month, and a prize (value £5) is awarded for the best paper read before the Society during the session. Casual communications are invited at all meetings, and a prize (value £1) is awarded at the end of the session for the best set produced.

One meeting during the session is set apart for the examination and discussion of cases of special interest, the patients being brought up for examination.

The meetings are held every month during the winter session in the Physics Lecture Theatre, adjoining the Conservation Room. The meetings take place at 4 p.m. on the second Friday in the month, and tea is served before the meetings in the Physics Laboratory (adjoining the Physics Theatre) for members attending the meetings. New men are strongly urged to attend and take part in these meetings, which, in the past, have proved instructive as well as interesting.

THE DEBATING SOCIETY.—President: Lauriston E. Shaw, M.D. Vice-Presidents: J. Fawcett, M.D., E. I. Spriggs, M.D., A. W. Ormond, F.R.C.S., M. S. Pembrey, M.D., A. R. Thompson, F.R.C.S. Hon. Secretaries: J. A. Ryle, J. R. Barrow-Clough, and a Committee of six students.

The Society has reached its nineteenth year. The subjects for debate are general and of interest alike to senior and junior men. The meetings are held on Saturday evenings in the Smoking-room, at least once a month. The first meeting will be held on October 9th. The president will take the chair.

THE GUY'S HOSPITAL GAZETTE.—The GAZETTE is published on alternate Saturdays throughout the year, and can be obtained from the Librarian. Each member of the Clubs' Union is entitled to a copy of each issue throughout the year; after five years, when he has become a life member of the Union, he is required to pay an annual subscription to the GAZETTE (and Reports) if he desire to continue taking them.

All Guy's men are invited to contribute to the GAZETTE, and all articles, accompanied by the sender's name, not necessarily for publication, should be placed in the Editor's box in the colonnade at least by the Tuesday preceding the next issue.

THE GUY'S HOSPITAL REPORTS.—Edited by F. J. Steward, M.S., and Herbert French, M.A., M.D.

The Reports are published annually, and each subscriber to the Clubs' Union is entitled to a copy, which he may obtain in the Wills Library from the Librarian. Each volume contains papers by members of the Staff of the Hospital and Medical School upon original work done in the Hospital during the preceding year; it also contains a list of the gentlemen who have been educated at Guy's Hospital, with the appointments they have held during the year, the examinations they have passed, and the prizes and honours they have won. The first volume appeared in 1836; copies of the earlier volumes can be obtained from the Editors. The value of this annual publication is obvious, and every Guy's man is proud of the original papers of its Staff, from those of Addison, Bright, and Hodgkin, to those of the present day.

THE CHRISTIAN UNION.—The Christian Union was started in 1849 by Dr. Habershon and Dr. Golding-Bird, who held meetings in their houses for students of Guy's and St. Thomas's Hospitals. Since that time similar institutions have been formed in all the London hospitals.

The Christian Union is now a part of the Student Christian Movement of Great Britain, which, again, is part of a world-wide brotherhood of Christian students, known as the World's Student Christian Federation. This movement was started in 1893, as an outgrowth of the Student Volunteer Missionary Union, which was formed in the previous year through the interest awakened by visits paid to several Universities and Colleges by Messrs. Stanley Smith and C. T. Studd, prior to their departure as missionaries to China, and also by the visits of Messrs. Forman and Wilder, who told of the growth of missionary enthusiasm in the colleges of America. At that time religious societies among students existed in only twenty British Colleges; to-day there are Christian Unions in 121 Colleges and Universities, with a membership of 4,500. The World's Student Christian Federation has a membership of over 103,000 in 40 different countries. Every year a summer camp conference is held at Baslow, with an attendance of about 600. During the Winter Term, conferences are held in London, and the last two years large gatherings of students have been held in the Mansion House and Guildhall.

The objects of the Christian Union are to lead students to become disciples of Jesus Christ, and to promote their spiritual life by regular meetings for prayer and Bible study.

The Missionary Society holds meetings every month.

During the winter term it has been arranged to hold a monthly meeting, at which an address will be given. Meetings will be held for conversational Bible study. Prayer meetings are held every day. The speakers and time of meeting will be announced later. Hon. Sec., C. Sherris.

THE STUDENTS' CLUB.—Officers till 1910 (March). President: W. Hale White, M.D.; Treasurer: John Faweett, M.D.; Hon. Secretary: H. C. Cameron, M.D.; Hon. Assistant Secretary: T. B. Layton, M.S.; and a committee of eight.

The above named manage the affairs of the Club, a full account of which will be found in the Clubs' Union Blue Book.

Guy's Hospital London University Club.

THIS Club was founded in 1889. Every London man at the Hospital should endeavour to become a member (see Rules 3 and 7). The next dinner will be held on the fourth Thursday in November.

OFFICERS, 1910—1911.

President: Dr. Hale White. *Vice-Presidents:* Mr. Symonds and Dr. Fawcett. *Honorary Treasurer:* Mr. F. Durham. *Committee:* Mr. C. H. Fagge, Dr. D. Forsyth, Mr. H. L. Eason, Dr. C. E. Iredell, Dr. J. Jewell, Mr. T. B. Layton, Dr. T. D. Lister, Mr. R. J. Reynolds, Mr. H. J. Spon, Dr. T. G. Stevens, Mr. R. T. Tanner, Mr. A. H. Todd. *Honorary Secretaries:* Mr. Kenelm H. Digby, and Mr. G. E. Genge-Andrews.

LIST OF MEMBERS.

Adeney, E. L., J.P., M.D., Howard Lodge, Mount Zion, Tunbridge Wells
Alexander, K. B., M.B., B.S., Cambridge, East London, South Africa
Alexander, S. R., M.D., Gatefield House, Faversham
Allan, A. P., M.D., B.S., Crogdene, Croham Road, South Croydon
Annesley, F. D., Guy's Hospital
Balderston, R., M.B., 17, Westbourne Road, Forest Hill, S.E.
Barber, H., M.D., 45, Friar Gate, Derby
Barron, B.M., I.M.S.
Basker, C. A., M.B., B.S.
Bennett, T. I., Guy's Hospital
Berry, F. Haycraft, M.D., Oxford House, Watford
Bird, Tom, M.A., 59a, Brook Street, W.
Black, G., M.B., B.S., The Willows, Hailsham, Sussex
Box, F. W., M.B., "Berwyn," Warwick Road, Stratford-on-Avon
Brailey, W. A., M.D., 11, Old Burlington Street
Branfoot, Surgeon-General A. M., India Office, Whitehall, S.W.
Bridger, J. D., 50, Dartmouth Road, Cricklewood, N.W.
Brock, E. H., M.D., 21, Streatham Hill, S.W.
Bruce, H. W., M.D., B.S., F.R.C.S., Southwark Infirmary, East Dulwich Grove, S.E.
Burgess, W. F. R., M.D., 23, Streatham High Rd., S.W.
Burghard, F. F., M.S., F.R.C.S., 86, Harley Street, W.
Butler, H. A. G., South Parade, Bangalore.
Caldecott, C., M.B., B.S., Earlswood Asylum, Redhill
Campbell, H. J., M.D., F.R.C.P., 36, Manningham Lane, Bradford, Yorks.
Carpmael, C. E., M.B., B.S., 125, Half Moon Lane, Herne Hill, S.E.
Carter, A. H., M.D., B.S., 9, George Street, Wolverhampton
Catto, W. H., M.B., B.S., Guy's Hospital
Cleveland, A. J., M.D., 8, Thorpe Mansions, Norwich
Cockrem, G. B., Guy's Hospital
Cole, T. P., Guy's Hospital
Coleman, E., M.B., B.S., 60, Cranbrook Road, Ilford
Collier, H. W., M.B., B.S., 71, Whitehall Park, Highgate, N.
Collins, V. E., M.D., Honolulu, Territory of Hawaii
Cook, F., B.Sc., Guy's Hospital
Cox, A. Neville, Guy's Hospital
Crook, H. E., M.D., B.S., F.R.C.S., Ivermore, Richmond Road, Twickenham
Cruickshank, J. D., The Lodge, Chingford, N.E.
Cuff, Robert, J.P., M.B., 40, Filey Road, Scarborough
Dakin, W. R., M.D., B.S., F.R.C.P., 8, Grosvenor Street, W.
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Dalton, B. Neale, M.D., 203, Selhurst Road, South Norwood, S.E.
Darke, S. J., M.B., B.S., Guy's Hospital
Davies, D. A., Guy's Hospital
Davies, W. L. Gwyn, Guy's Hospital
Davy, Henry, M.D., F.R.C.P., Southernhay House, Exeter
Dick, F. A., L.R.C.P., M.R.C.S., Guy's Hospital
Digby, K. H,, M.B., B.S., Guy's Hospital
Dunderdale, G., L.R.C.P., M.R.C.S., Guy's Hospital
Dunn, L. A., M.S., F.R.C.S., 9, Park Crescent, Portland Place, W.
Durham, F., M.B., F.R.C.S., 34, Dover Street, W.
Durham, H. E., M.A., M.B., B.C., F.R.C.S., Broomy Hill, Hereford.
Duvivier, E., M.B., B.S.
Eason, H. L., M.D., M.S., 37, Queen Anne Street, W.
East, W. N., M.D., 2, North Road, Clapham, S.W.
Eastes, G. L., M.B., B.Sc., 83, New Cavendish Street, W.
Edmunds, H., Guy's Hospital
Edsall, R. C. V., M.B., B.S.
Evans, H. W., Guy's Hospital
Evans, T., M.B., B.S.
Every-Clayton, L. E. V., M.D., B.S., F.R.C.S.
Fagge, C. H., M.S., F.R.C.S., 3, Devonshire Place, W.
Fawcett, J., M.D., B.S., F.R.C.S., F.R.C.P., 66, Wimpole Street, W.
Fielden, W. E., M.D., Burlington Street, Chesterfield
Fisk, E., M.D., B.S., Lindfield, Crescent Rd., Ramsgate
Floyd, S. G., M.D., B.S., Lister House, Grays, Essex
Forsyth, D., M.D., 43, Queen Anne Street, Cavendish Square, W.
Fox, H. E. Croker, M.B., Charlbury Lodge, near Weymouth.
Fox, W. E., L.R.C.P., M.R.C.S., Guy's Hospital
Gardener, A. L., L.R.C.P., M.R.C.S.
Genge-Andrews, G. E., Guy's Hospital
George, W. S., Guy's Hospital
Glendining, V. B., Guy's Hospital
Golding-Bird, C. H., F.R.C.S., Pitfield Cottage, Meopham, Kent
Goodall, E. W., M.D., Eastern Fever Hospital, Homerton, N.E.
Green, A., M.B., Newbold Gate, Chesterfield
Greenwood, A. A., M.B., B.S.
Halstead, G. D., M.D., Albion Hill House, Ramsgate
Hamilton, E. T. E., M.D., M.S., F.R.C.S., B.Sc., P.O. Box 1750, Johannesburg, Transvaal
Handley, W. S., M.D., M.S., F.R.C.S., 12, New Cavendish Street, W.
Handson, L. E. C., M.B., B.S., Hadley Hurst, Polegate, Sussex
Hardenberg, E. F. H., M.B., Duffield House, Upton Road, Watford
Haycraft, G. F., L.R.C.P., M.R.C.S.
Hazell, F., M.B., B.S., 1, Bouquet Street, Capetown
Heatherley, F., M.B., B.S., F.R.C.S , Endellion, Rock Ferry, Birkenhead
Hetley, Henry, M.D., 114, Church Road, Upper Norwood, S.E.
Hewetson, Major, Navaho, The Grove, Church Road, Finchley, N.
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Hickes, C., 78, Upper Richmond Road, East Sheen, S.W.
Hickes, P. L.

Hickman, H. V., M.B., The Hollies, Wanstead, N.W.
Hilton, C. T., M.B., B.S., New Albernia, British Columbia
Hoare, E. S., 17, Lupus Street, S.W.
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Jones, R. O. Hilton, Guy's Hospital
Jones, T. Lewis, Guy's Hospital
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Nason, J. J., M.B., J.P., Church House, Stratford-on-Avon
Norbum, A. E., M.D., Oldfield Park Lodge, Wells Road, Bath
Owsley, G. C., M.B., 5, Montpellier Road, Blackheath
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Pakes, W. C. C., Leper Asylum, Orange River Colony, South Africa
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Penny, E., M.D., The Hermitage, Marlborough
Penny, E. A., L.R.C.P., M.R.C.S., Guy's Hospital
Perkins, H. E., L.R.C.P., M.R.C.S.
Price, P. S., L.R.C.P., M.R.C.S.
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Richmond, John, Saville Club, Piccadilly
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Robinson, W., Guy's Hospital
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Scott, Arnold, M.D., Bocking, Braintree, Essex
Scott, E. D., Guy's Hospital
Scott, M., Guy's Hospital
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Shaw, Lauriston E., M.D., F.R.C.P., 64, Harley St., W.
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Sherwood-Stocker, J., M.D., 18, Porchester Square, W.
Smith, G. Bellingham, F.R.C.S., 13, Queen Anne St., W.
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Smith, L. Muir, Guy's Hospital
Spon, H. J., 23, Southwark Bridge Road, S.E.
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Starling, E. H., M.D., B.S., F.R.S., F.R.C.P., 40, West End Lane, N.W.
Starling, H. J., M.D., 45, All Saints Green, Norwich
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Stout, T. D. M., M.B., B.S., Guy's Hospital
Stringer, L. B., Guy's Hospital
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Symonds, C. J., M.S., M.D., F.R.C.S., 58, Portland Place, W.
Tanner, John, M.D., 4, Claremont House, Lithos Road, Hampstead, N.W.
Tanner, W. E., Guy's Hospital
Targett, J. H., M.S., F.R.C.S., 19, Upper Wimpole Street, W.
Taylor, A. E., F.R.C.S., 26, Lancaster Gate, W.
Taylor, E. C., M.S., Eland House, Rosslyn Hill, N.W.
Taylor, Frederick, M.D., F.R.C.P., 20, Wimpole St., W.
Thomas, F. L., M.B., B.S., The Square, Barnstaple, N. Devon
Todd, A. H., B.Sc., Guy's Hospital
Tressider, W. E., M.B., B.S., Paignton, Devon
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Uhthoff, J. C., M.D., Wavertree House, Hove, Brighton
Waddy, H. E., Rhossili, Brunswick Road, Gloucester
Wade, J., D.Sc., Hunstanton Lodge, Downe, Kent
Wakefield, C. F., Waywell, Norwood Hill, Charlwood. Surrey
Walker, F. E., M.B., B.S., St. Andrew's, Uxbridge
Wallace, R. V., M.B., Darenth Lodge, 133, Clapton Common, N.
Watkin, P. J., Guy's Hospital
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White, W. Hale, M.D., F.R.C.P., 38, Wimpole St., W.
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Williams, R. E., M.B., 21, The Common, Woolwich
Wilson, O. R. L., Guy's Hospital
Young, J. D., M.D., 94, Stamford Hill, N.
Young, W. A., Guy's Hospital
Zorab, A., M.B., B.S., Eltham Park, Eltham

RULES.

1. The Club shall be called the "Guy's Hospital London University Club."

2. The objects of the Club are to promote social intercourse among London University men who have received, or are receiving, their medical education at Guy's Hospital; and to further the interests of both the Hospital and the Medical Faculty of the University.

3. All Graduates and Undergraduates of the University of London who are, or have been, medical students at Guy's Hospital are eligible for membership of the Club.

4. The affairs of the Club shall be managed by a Committee consisting of a President, two Vice-Presidents, a Treasurer, two Secretaries, and twelve other members; five to form a quorum, and the Chairman to have a casting vote.

5. The President shall be elected for one year only, and that he take the chair at the corresponding Annual Dinner. All other officers and members of Committee be elected for one year. Their election shall take place at the Annual General Meeting.

6. Committee Meetings shall be called by the Secretaries at such times as they shall consider necessary, or at the request of not less than three members of the Committee.

7. Candidates for membership must be proposed and seconded by members of the Club, and the election shall be conducted by the Committee, the votes of two-thirds of those present at a Committee Meeting in favour of a candidate being required for his election.

8. The Annual General Meeting shall be held some time in November, the day to be fixed by the Committee, and on the same evening the Annual Dinner shall take place.

9. Other General Meetings for the discussion of questions of University interest or for social purposes shall be called at the discretion of the Committee.

10. The administration of surplus funds shall be in the hands of the Committee.

11. The Committee may by a unanimous vote propose the expulsion of any member of the Club, and if this vote is confirmed at a General Meeting (to be specially called for the purpose) by a majority of those present, he shall cease to be a member of the Club..

12. At the Annual General Meeting the Treasurer shall present a statement of the Accounts of the Club, duly audited by two members, of whom only one may be a member of the Committee.

13. No alteration of, nor addition to these Rules, shall be made, except at the Annual General Meeting, due notice of such alteration or addition having been given in writing to a Secretary at least one month before the meeting, and notice of the same having been given to every member of the Club, fourteen days at least before such meeting.

Guy's Colonial Club.

The above club was founded in order that students at Guy's who come from the Colonies should have an opportunity of meeting one another. A dinner is held annually, with Mr. Charters J. Symonds, the President, in the chair, and this year will probably be held early in November.

All new Colonials are asked to communicate with one of the Secretaries :— L. B. STRINGER,
H. J. HOBY,
W. S. STRANACH.

Change of Address.

G. H. Field, M.B., B.C. Cantab., M.R.C.S., L.R.C.P. Lond., from Christchurch Road, Boscombe, Bournemouth, to Sarratt Hall, near Rickmansworth, Herts.

W. Gibson Parker, M.B. Lond., D.P.H. Camb., from 2, The Avenue, Taunton, to Shirley, Hazeldene Road, Weston-super-Mare.

C. B. Penny, M.B. Lond., M.R.C.S., L.R.C.P., from 37, Walbrook, E.C., to Sunnyside, Teville Road, Worthing.

Mrs. Sam Thompson (*née* Jenny Thomas), from Guy's Hospital Nurses' Institution, St. Thomas's Street, S.E., to Plas Iolyn, Ruthin, North Wales.

BOOKS RECENTLY RECEIVED IN THE WILLS LIBRARY.—Whitelocke's Sprains and Allied Injuries of the Joints; Gadd's Synopsis of the B.P., 1898; Skellern's Descriptive Anatomy; Hart's Evolution and Heredity; Fein's Rhinology and Laryngology; Carnegie Brown's Amœbic or Tropical Dysentery; Langdon Brown's Physiological Principles in Treatment; Porter's Sanitary Law; Walton's Fractures and Separated Epiphyses; Vols. 50 to 65 of the Zeitschrift für Hygiene und Infectionskrankheiten, presented by Dr. King Brown.

Births.

CARD.—On September 2nd, the wife of Alfred Card, M.R.C.S. Eng., L.R.C.P., of Muswell Rise, N., of a son.

WILBERFORCE SMITH.—On September 5th, at West End Avenue, Pinner, Alsie, wife of D. Wilberforce Smith, M.B., B.S. Lond., of a son.

Ed.—A. N. C.

GUY'S HOSPITAL GAZETTE.

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Passim.

WE take this opportunity of again reminding all Guy's men, past and present, of the Conversazione which is to be held on Friday, October 8th, to inaugurate the new session of the Physical Society. The hon. president and several of the vice-presidents hope to be present, and the function will give the opportunity to old Guy's men of meeting their contemporaries, as well as of seeing some of the recent developments of pathological and other scientific work at the hospital. We should add that the Conversazione will be held in the Medical School Buildings, and that evening dress will be worn.

THE following appointments have been made by the House Committee upon the recommendation of the Medical Committee:—House Physicians: E. L. Elliott (Dr. Hale White), V. T. P. Webster (Sir Cooper Perry): House Surgeons: R. C. H. Francis (Mr. Symonds), L. Bromley (Sir Alfred Fripp); Out-patient Officers: G. H. Hunt, F. Kahlenberg, J. G. Saner, N. A. D. Sharp; Assistant House Surgeons: T. D. M. Stout (Mr. Steward), W. T. Clarke (Mr. Fagge), H. Gardiner (Mr. Rowlands), E. P. Poulton (Mr. Turner). Mr. S. J. Darke has been appointed house surgeon to Mr. Dunn for three months, to fill the vacancy caused by Mr. Johnston's resignation.

IT is satisfactory to announce, in connection with the camp of the London University Officers' Training Corps, that Lieut.-Col. James desires to convey to the officers and men of the medical unit his satisfaction with the amount of training which has been done and the way in which the work has been carried out during the past year. Freshmen who desire to enter the Corps should see the notice on another page of this issue, and give in their names on one of the days there mentioned.

THE following letter, recently received at the hospital, is another example of the extraordinary workings of some minds in connection with medical matters. The letter is addressed to Sir

William Gull, who died twenty years ago :—

Sir William Gull,

Dear Sir,—The other night I heard an ardent temperance reformer make this statement, "That in Guy's Hospital a brewer's drayman was admitted with a cut hand. He died, and little gas jets were placed on his body and they were lit." To me this statement seems obsolete. He said, "that if I wrote to you, you would endorse what he said." I write this letter with no prejudiced feeling against Mr. ———, but for my own personal knowledge. Will you please say at your earliest convenience whether his statement is true or not, and could you inform me of the kind of gas emitted from the man's body which ignited? Thanking you in anticipation, etc.

The following has been sent to us as a true verbatim report of a Borough patient's remarks on reaching home after spending a Wednesday afternoon in the Out-Patient Department :—

"Yus, thank 'eavens, I think Guy's 'as done me some good at last! On the card I was to see Dr. Faggy, but Faggy, 'e was away on 'is 'olidays or somewhere, so I didn't see 'im, but only one of the stoodents. 'E said 'e thought 'e could disperse it, and gave me a bottle of medicine. But I 'ad to pay 8d.—extortion I calls it, when a man 'aint 'ad no work for five months, and only 'as 2s. 4d. comin' in besides 'er Old Age Pension. 'Owever, I aint one to complain, but there must be something wrong somewhere, 'cos they only put down 2d. on the card—I never knew a place where there wasn't deceit yet. Any'ow the next week I went up, and 'e said I must be tapped. So 'e tried, but 'e couldn't draw it orf. Then 'e run orf ter find the doctor. I ses to him 'If you can't do it better than this, I shall 'ave to go to a surgeon.' 'Is instruments must 'ave been blunt or something. But what I ses is they ought to look after them better. I don't fancy they're exact enough about them. I recollect when I was in Bartholomew's seein' a rusty old pair of scissors. There's many a man don't trouble about 'is tools when 'e's done using them. But they ought to put 'em in sweet oil ter keep 'em proper. Then when 'e couldn't succeed in the tapping business, 'e put on some 'ot burning stuff ter kill the germs. I tried to persuade 'im not to. I told 'im it was no manner of use as I 'ad washed with 'Udson's extract before I came up. But 'e put me orf with some medical words or other, and told me to come up next Wednesday.

But since then a most m'rac'lous thing 'as 'appened—well, magic, I calls it. Whether it was Faith-'ealing or not—I believe there's something in that Faith-'ealing, yer know—not Faith without works I don't mean—or if it was the 'Udson's—but anyway, the swelling 'as gone down marvellous, and I'm goin' up Wednesday to tell 'im, and encourage 'im a bit."

The Residents' going-off dinner was held on Thursday last, and a large and distinguished company gathered to bid good-bye to President Evans, Vice-President Brown, and the other off-going residents—Messrs. Lees and Johnston—and to welcome the new president, Mr. Mills, and the new vice-president, Mr. Fitzmaurice. The toast of "The Visitors" was proposed by Mr. Lucey, and Mr. Brookhouse replied. The speech of the evening, perhaps, was Mr. Endean's in reply to a toast to the Colonials who are leaving us. After the dinner there was a pleasant innovation in the shape of a sing-song in the Smoke Room, to which Messrs. Ryley, Evans, Eccles, Endean, and Featherstone contributed songs, Mr. Renton recitations, and Messrs. Jarvie and Trethowan accompaniments.

Dental News.

Congratulations to Mr. H. E. Shepherd, who has added to his many other trophies the Dental Society's Prize for the best paper read before the Society during the last Session (1909–1910).

Congratulations are also due to Mr. J. H. Rhodes on obtaining the prize for Operative Dental Surgery.

From the Gazette's Special Pathologist.

H.J.H., Amersham.—A smear preparation taken direct from this swab, showed the presence of Klebs Loffler Bacilli.

H.J.H., Amersham.—This specimen shows no evidence of a malignant growth. There are one or two areas of inflammatory leucocytes over which the mucous membrane is thinned, and there is some slight inflammation of the mucous glands beneath. All this is consistent with some simple chronic irritation.

PATHOLOGIST.

Some Notes on Two Cases of Aortic Aneurysm Communicating with the Superior Vena Cava which have recently been in the Wards.

BY L. C. DUNDAS IRVINE.

Case 1.—T. S., aged 43, a costermonger, was admitted into Stephen, under Sir Cooper Perry, on May 2nd, 1910, for "shortness of breath." The only previous illness of importance was syphilis, which he had contracted in 1890. His "trouble" he attributed to a sudden strain when lifting a heavy crate a week before Xmas, 1909.

He was suddenly taken dizzy, became black in the face, and noticed a swelling near the right nipple. He went to St. Thomas's Hospital, and was kept in ten days, at the end of which he was discharged as an out-patient. He suffered with pain, headache, and shortness of breath, the last of whlch became so bad that by the end of January he was confined to the house. The pain was at the lower end of the sternum towards the left side. About this time he noticed hoarseness of his voice, diplopia and dysphagia; and in January also dilated venules began to appear on his chest. On May 2nd, having been told that his complaint was incurable, he tried to cut his throat, but was prevented before anything but a superficial wound had been made.

On admission he was conscious, his breathing was stertorous, his voice husky, and his face cyanosed. His heart was normal in size, and a systolic murmur was audible over the whole of the præcordial area, loudest over the aortic valves, and traceable up into the root of the neck. His pulses were equal, and of medium tension. There was no deformity of the chest.

Of pressure symptoms he had shooting pains down both arms, but there is no mention of any post-auricular pain.

There was deficient movement, and diminished tactile vocal fremitus over the lower half of both chests. On both sides there was dulness, and deficient breath and voice sounds reaching from the second rib in front, the fourth rib in the axilla, and the spines of the scapulæ behind, to the bases of the lungs. Above the dull area rhonchi of various pitches were audible.

The dysphagia was well marked, there being difficulty in swallowing solids unless well washed down.

There was œdema of both arms, many dilated venules on his chest, some long tortuous veins on his abdomen, and some on his back. The flow in all of them was from above downwards.

Hoarseness and diplopia are mentioned as having appeared in January, but are not referred to in detail, and his pupils are said to have been equal and normal in reaction.

His pulses, as mentioned above, were equal, and there is no mention of any tracheal tugging.

The patient was tapped on the right side of his chest and three pints of yellowish albuminous fluid were drawn off, with considerable improvement in his condition. However, the hydrothorax recurred, and although he was needled on four different occasions, it was without result. He became more dyspnœic, cyanosed, and œdematous, his pulse got weaker, and he finally died on May 17th.

At the autopsy, in addition to the signs of heart failure, there was a large saccular aneurysm of the aorta which would about contain a standard billiard ball. It began immediately above the aortic valves, and ceased below the emergence of the innominate artery. On its upper margin, about one inch from the innominate artery, there was a clean-cut hole, about a quarter of an inch in diameter, communicating with the superior vena cava. This latter vein was widely dilated at this point, forming a cavity as large or larger than that of the aneurysm, and involving the last inch of both innominate veins. Below the communication the vena cava was very stenosed, so that a quill, passed from the cavity into the right auricle, was firmly gripped. There was general atheroma of the aorta, with calcareous deposits.

Case 2.—A. B., aged 45, a printer's porter, was admitted into Stephen, under Sir Cooper Perry, on September 4th, 1910, for œdema of the face, chest and arms. He had been a heavy drinker in his youth, and had had syphilis in 1880. Twelve years ago he was swinging a heavy ream of paper on to his shoulder when he says "something gave" inside him, and he fainted. With this exception he seems to have enjoyed fairly good health until nine months ago, when the œdema appeared. Other symptoms gradually followed, with the addition of a peculiar one, namely, a great tendency to drop off suddenly asleep, even when eating a meal, awaking a few seconds later with a start.

His heart is slightly enlarged, dulness extending half an inch to the right of the sternum, and slightly to the left beyond the mid-clavicular line. A systolic murmur is audible at the apex of the heart, traceable to the right of the sternum, and round to the left axilla.

At the second right intercostal space a "to-and-fro" murmur can be heard which can be traced up to the right clavicle, changing its quality. At the level of the clavicle, and in the right supra-clavicular space, a loud "bruit de diable" can be heard of a peculiarly high pitch, reaching its maximum intensity immediately after the first heart sound, and its minimum during diastole. The right side of the chest is "fuller" than the left, but no pulsation can be felt. There is dulness on the right side of the chest from the clavicle above to the fourth rib below, and from the mid-clavicular line to the sternum.

Of pressure symptoms: there is no pain except a slight localised tenderness in the right supra-clavicular space.

There is a small area at the apex of the right lung where the breath-sounds are harsh and exspiration is prolonged. Otherwise the lungs are normal.

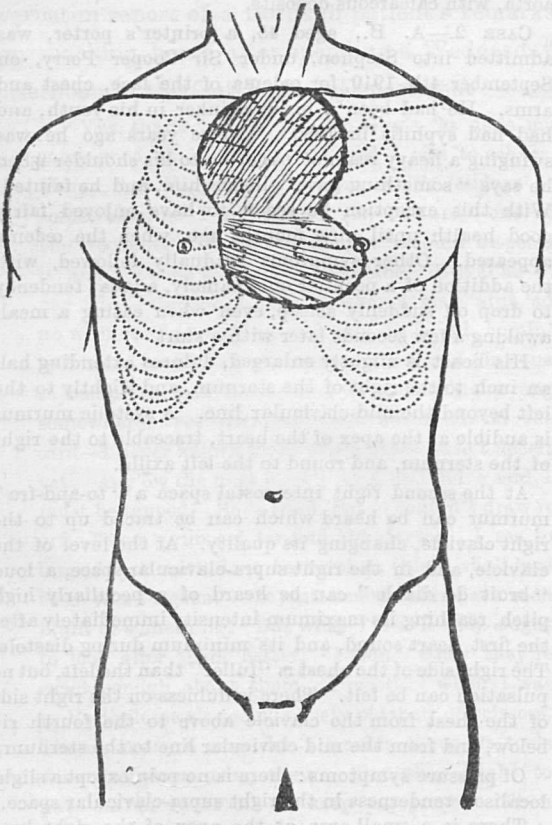
At nights, when asleep, he exhibits a curious form of dyspnœa. He lies on his right side, very cyanosed, and takes about eleven breaths without getting any air

whatever into his lungs. Then he takes four or five loud crowing breaths, which slightly relieve his cyanosis, after which he begins his abortive breathing again. And all this without showing any signs of disturbing his sleep, which remains profound throughout.

There is no dysphagia. There is very marked œdema of the face, neck, arms, and chest, the eyelids are nearly closed, and the eyes and nose are continuously "running." There is a ring of dilated venules, about three inches wide, running completely round the body at the level of the attachment of the diaphragm. The blood in these flows downwards.

His voice is unaffected, and his eyes react normally, the pupils being equal. The left pulse is greater than and slightly precedes the right. There is no tracheal tugging. Since the patient has been in bed there has been considerable improvement in the œdema.

An X-ray tracing of Case 2 shows a large fusiform aneurysm of the ascending and transverse arch of the aorta extending up into the root of the neck behind the sterno-clavicular joints.



Case 2.

A diagnosis of aneurysm of the ascending aorta with communication between the aneurysm and the superior vena cava has been made by both Sir Cooper Perry and Dr. French.

Obituary.

William Thomas Law,

M.D. Edin., F.R.C.S. Eng., L.S.A.

Dr. W. T. Law, whose death took place at Bournemouth, after an operation for cholelithiasis, on September 6th, was born on September 13th, 1845. He was the son of the late Mr. Henry Compton Law, of Allington, by Elizabeth, second daughter of the Rev. John Taylor, the pluralist Rector of Willand and Vicar of Imber and Llanarthney, Chaplain in Ordinary to Queen Caroline. His early leanings were towards a military career, but those were the days of purchase, and pecuniary considerations prevented the realisation of his desires, and afterwards, when launched as a member of our profession, the Army Medical Service did not attract him. He became an articled pupil to the late Mr. S. S. Larcombe, of Castle Cary, and entered Guy's Hospital in the medical year of 1867–8. Having been thus apprenticed to a Licentiate of the Society, he was enabled to take the qualification of L.S.A. after two years and eight months of hospital work, being naturally among the first of his standing by several months to become qualified, among his fellow students being Tom Jones, Batchelor, Golding-Bird, Jacobson, Mahomed, R. T. Pye-Smith, Sir George Pilkington, Arthur Cooper, Paramore, Connolly, Ewart, and others well known in the profession.

In 1870, in company with his friend and fellow student, W. P. Nesbitt, he entered at Edinburgh University. In Edinburgh he worked first in the wards of the late Sir J. Grainger Stewart, with Alex. Hughes Bennett, Knowsley Thornton, and Dr. R. Saundby, and at a later date was clinical clerk, with J. E. Shaw and others, to Lord Lister. He was appointed Resident Physician in the Royal Infirmary for a year, first in Dr. D. Haldane's wards and afterwards in those of Dr. G. W. Balfour, one of his co-workers in the latter's wards being R. A. Gibbons. Though that great trio, Goodsir, Syme, and Simpson, had passed away, the glories of Edinburgh were safe with Lister, Christison, Hughes Bennett Senior, Matthews Duncan, Laycock, Maclagan, P. H. Watson, Annandale, and Joseph Bell, to say nothing of the pure scientists, such as Turner, McKendrick, Crum Brown, Dewar, Allman, P. G. Tait, and others. Law at this time had little idle time on his hands, for besides continuous work in the wards, lectures in plenty and class examinations, he had to get through four examinations for the M.B., Greek and Logic for the M.D., in addition to three for the Royal College of Surgeons of England, which then demanded a special preliminary examination for its Fellowship, comprising Greek, one modern language, and other extra subjects. These sometimes came close together, and in April and May, 1871, the First M.B. at Edinburgh, the Final Examination for the M.R.C.S. of England, and the Primary Examination for the Fellowship of the same College were crowded into about five weeks. It was at this last examination that a noted anatomical conundrum was set which aroused much

hostile comment, for it required an exact description of the dissection required to expose from the outside the otic ganglion. As only four questions were set and all had to be answered, there was apparently some ground for complaint. Law, however, surmounted the obstacles, and was thenceforward able to devote his attention to the duties of Resident Physician, with which was united the care of Dr. Matthews Duncan's gynæcological ward.

In August, 1872, he was appointed Assistant Medical Officer at the Chorlton Hospitals, Manchester, then a large newly-created building on the pavilion plan. While here, he took the M.D. degree with special distinction for a thesis on Mitral Stenosis, and two years afterwards came to London and took temporary charge of one of the Metropolitan Asylums Board's hospitals at Hampstead, and when that body were seeking a Medical Superintendent for a large new institution for feeble-minded children, Law was one of the three selected candidates. Shortly afterwards he was appointed House Physician at the Seamen's Hospital at Greenwich, as successor to Dr. Andrew Duncan, Dr. Stephen Ward and Dr. C. H. Ralfe, of the London Hospital, being the visiting physicians at the time. The latter was then investigating scurvy, and a good deal of urinary analysis was carried out by Law in furtherance of these researches. His resident surgical colleagues were Mr. Johnson Smith, and for a time Mr. (now Sir George) Plunket O'Farrell, of Dublin, with whom, as well as with Dr. Ralfe, he remained on terms of cordial friendship. While at Greenwich he passed the Final Examination for the Diploma of F.R.C.S. About May, 1876, the post of Resident Medical Officer at the Brompton Consumption Hospital fell vacant. The appointment, a very desirable one, was at that date filled by open competition from without, and the applicants were very numerous, but Law was appointed.

After several years of agreeable work at Brompton he became somewhat anæmic, and was advised to live at St. Leonards. Early in 1880 he began to practise there. He had, shortly before this, married Georgiana, second daughter of His Honour Judge Price, Q.C., Recorder of York and County Court Judge for West Norfolk.

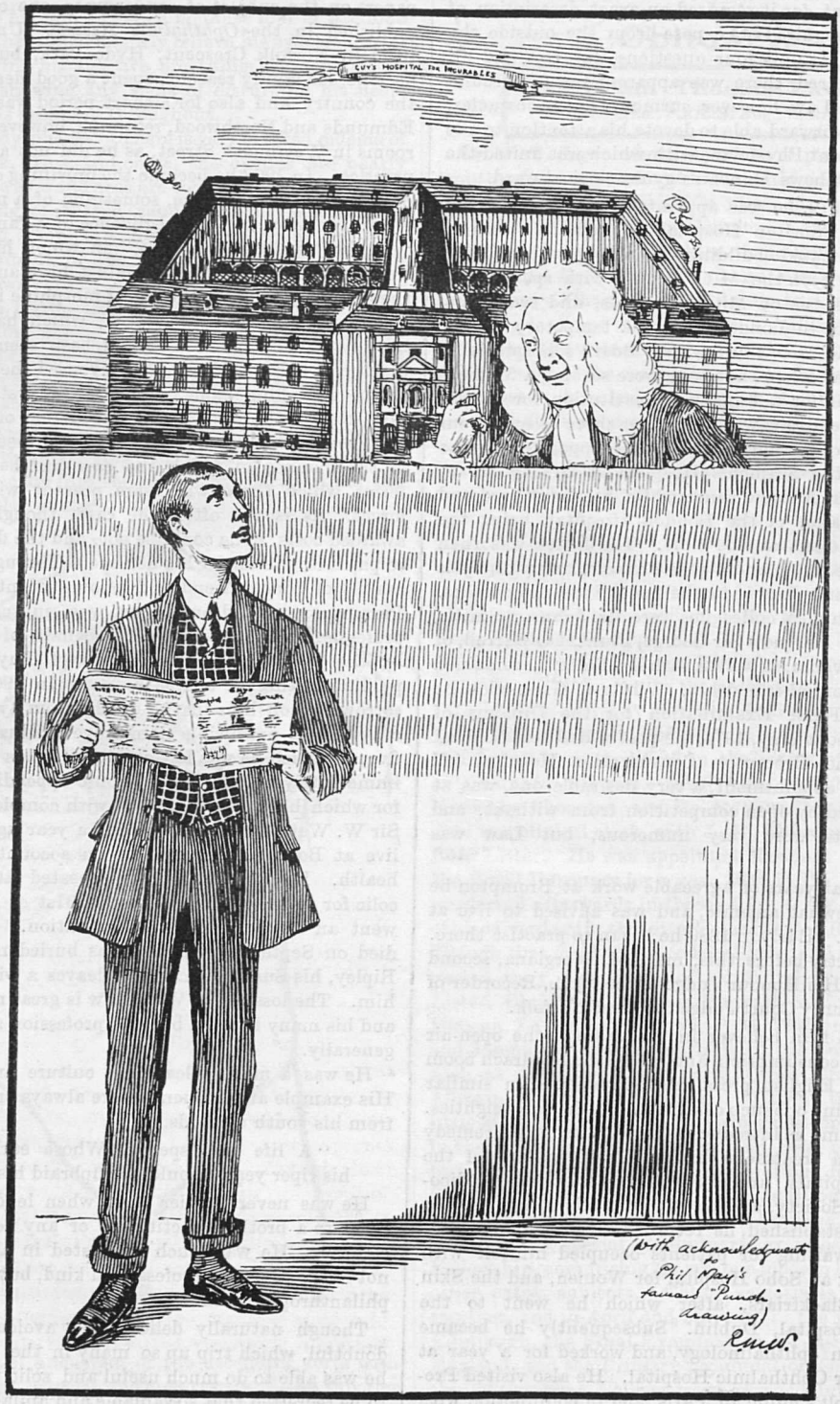
Law was a firm believer in the value of the open-air treatment of consumption, and before the Nordrach boom began in the English press, treated patients on similar lines, publishing one such case treated in the early eighties. About this time he introduced sodium nitrite as a remedy in epilepsy, a treatment that was tried at some of the London hospitals, and was discussed at the Medico-Chirurgical Society, and elsewhere. His health having become re-established, he returned to London in 1885, and while waiting for patients occupied himself with clinical work at Soho Hospital for Women, and the Skin Hospital, Blackfriars, after which he went to the Rotunda Hospital, Dublin. Subsequently he became interested in ophthalmology, and worked for a year at Westminster Ophthalmic Hospital. He also visited Professor Landolt's clinic in Paris, and in conjunction with that *savant* translated some of his French and German papers on the subject of convergence, one of which was published in the *Ophthalmic Review*. Until 1895 he lived in Norfolk Crescent, Hyde Park, but after that date he, for family reasons, spent a good deal of time in the country, and also for a short period was in Bury St. Edmunds and Northwood, retaining, however, consulting rooms in Weymouth Street, as he did not attempt local practice. In 1902 he became the unwilling central figure of what was, at the time, something of a medical *cause célèbre*, as an action for negligence of a familiar type of "heads I win, tails you lose," in which huge damages were claimed, was brought against him, and turned on the circumstance that the use of morphine in an intractable case of spasmodic asthma, which had defied the most varied treatment and had been seen by eminent members of the profession, had favoured the acquirement of the morphine habit. After four days' hearing the jury stopped the case, saying the action ought never to have been brought, while the Judge expressed his opinion of the manner in which the case had been got up in terms which those who were present will not easily forget. As is too often the case, though technically awarded costs, none could be got, and the defendant had to pay a large sum for his defence. Through the efforts mainly of his old friend and fellow student, Dr. Richard Paramore, a handsome sum was subscribed by the profession, and presented, on behalf of the donors, by the President of the College of Physicians, at a public meeting of sympathisers. In 1906 a crushing sorrow fell on him in the death, from typhoid, of his only son, a promising Cambridge graduate of twenty-five, by which he was left childless. This event seemed immediately to light up a chronic appendicular trouble, for which he was operated on with complete success by Sir W. Watson Cheyne. About a year ago he came to live at Bournemouth, chiefly on account of his wife's health. He had suffered from repeated attacks of biliary colic for seven years, and on the 31st of August underwent an operation for that condition. He, however, died on September 6th, and was buried near his son at Ripley, his Surrey home. He leaves a widow surviving him. The loss of Dr. W. T. Law is great not only to her, and his many friends, but the profession and the public generally.

He was a man of learning, culture and refinement. His example and influence were always on the right side from his youth upwards.

> "A life well spent! Whose early care it was
> his riper years should not upbraid his green."

He was never happier than when lending a helping hand to a brother practitioner or any needing aid and counsel. He was much interested in all good causes, not only of a purely professional kind, but of a social and philanthropic nature.

Though naturally delicate by avoidance of things doubtful, which trip up so many in the journey of life, he was able to do much useful and solid work, and it is to be regretted that so valuable and amiable a life is now at an end.



Thomas Guy: "Well, young man, what profession are you thinking of adopting?" The Youth: "Medicine."
Thomas Guy: "For a living?" The Youth: "Yes."
Thomas Guy: "COME INSIDE."

Glaucoma.

CLINICAL LECTURE BY H. L. EASON, M.D., M.S.

Gentlemen,—It was said by the dying Mary Tudor that the word "Calais" would be found graven on her heart, and I should be glad if every one of you went into private practice with "Glaucoma" similarly impressed on his mind. As the result of advances in ophthalmic medicine and surgery, the ultimate effects of many ocular affections are much less grave than formerly, and, in contrast, glaucoma remains the most hopeless, terrible disease that may attack the vision. In its chronic form there is little hope of arresting its progress; it is so insidious in its onset that it is often not noticed by the patient till irreparable damage has been done, and it is frequently mistaken in practice for other inflammatory affections, with the result that treatment aggravates the disease instead of relieving it. Both the mistakes that are made in its diagnosis, and its insidious and slow progress in the chronic form, have been brought very forcibly to my mind quite recently by three cases seen in the Out-patient Department. The first was that of a woman who had been treated by her doctor with atropine for nearly six months under the impression that she was suffering from iritis, or some similar affection; at the end of that time she attended the hospital totally blind in one eye, and with very little sight left in the other. The condition was so advanced that an operation, though the only thing left to do, was of no benefit.

The second case was that of an old lady who was sent up to us for a report on her cataract, with a view to operation. It was true that she had obvious cataract in both eyes, but her loss of vision was not due to the cataract, which was only partial, but to chronic glaucoma, which had not been observed.

The third case was that of a Jew tailor. I mention this fact because I am under the impression that glaucoma is more common among Jews than other races, and it is well known that tailors and others who work continually at fine close work are unusually liable to the disease. This man came up to the hospital because he found that his sight was getting dim, and he wanted to know if anything could be done for it by the aid of glasses. He had almost lost the sight of one eye without noticing it, and his field of vision in the other eye was extremely limited, and his visual acuity was diminished to one-fourth of normal. This was all due to chronic glaucoma of a very insidious variety.

These three patients had, therefore, come to us too late to enable us to do anything which might check the progress of the disease, much less offer them any hope of return of the sight which had been lost, and it is with a view of impressing on you the immense importance of an early diagnosis of glaucoma that I have chosen it as the subject of this lecture.

Definition.—Now, what is Glaucoma? The definition is very simple; it is an affection in which there is an increase in the normal intra-ocular tension, and the eye is harder than it should be, and in which, as a sequel, the globe gives way at its weakest point, the entrance of the optic nerve, causing the characteristic cupping or excavation of the optic nerve head. The symptoms may vary in severity, but the disturbance to the retinal circulation and the pressure on and subsequent atrophy of the optic nerve are the ultimate causes of the loss of sight in every case.

Pathology.—The pathology is not so simple, though the cause of glaucoma is evidently due to some disturbance of the processes that tend normally to keep the intra-ocular tension at a proper level. It has been shown by experiment that the intra-ocular tension is governed by the normal secretion and exit of lymph from the eye, particularly that large collection, the aqueous humour, that fills the space between the cornea and the iris, and between the iris and the lens. You should, therefore, remember the normal mechanism for the secretion of the aqueous and for its exit from the eye. You will then more easily appreciate the causes of glaucoma and the methods devised for its treatment.

The aqueous is secreted by the lining epithelium of the ciliary body; it fills the posterior chamber of the eye, between the iris and the lens, enters the anterior chamber through the pupil, the iris being impervious to fluids, and leaves the anterior chamber through meshes in the angle of that space. On the posterior surface of the cornea there is a transparent membrane, the membrane of Descemet, which at the periphery of the cornea breaks up into numerous bundles; these bundles are termed the *ligamentum pectinatum*, and the spaces between them are termed the *spaces of Fontana*. These latter communicate with a circular channel or sinus in the cornea at its junction with the iris, termed the canal of Schlemm,

which is the only exit for the greater part of the aqueous in the anterior chamber. From the canal of Schlemm the aqueous passes into the ciliary veins, and so into the general circulation. A certain amount of fluid finds its way into the lymph spaces of the iris, and into the deep lymph spaces beneath the choroid, but the proportion drained through these channels is small compared with that which drains normally through the angle of the anterior chamber and into the canal of Schlemm. Anything, therefore, which tends to obstruct the outflow of lymph will increase the intra-ocular tension and cause glaucoma.

The disease may be primary, in which it does not follow previous ocular disease, or secondary, in which it follows some previous inflammatory affection, such as iritis or irido-cyclitis. Both varieties may be acute or chronic, and as the pathology of secondary glaucoma is simpler to understand, this condition will be considered first. As has been said before, any condition which obstructs the normal outflow of lymph will cause glaucoma, and the commonest site for the obstruction is the angle of the anterior chamber, or the pupil. For example, in an eye in which there has been severe inflammation, not only of the cornea, but of the iris, there may be much thinning of the cornea, with bulging and protrusion of it and the iris. As the result, the iris is adherent to the posterior surface of the cornea all round, and any exit for the lymph by means of the angle of the anterior chamber is blocked, resulting in secondary glaucoma. As a result of certain injuries to the eye, a similar condition may obtain. A patient has had a cut through the cornea, which has healed up, with a portion of the iris incarcerated in the wound, and with some inflammatory exudate. As a result, the iris is drawn forward, and probably attached to the posterior surface of the cornea, again causing an obstruction to the free exit of lymph through the angle.

But the commonest cause of secondary glaucoma is iritis, or iridocyclitis. In these conditions the inflammatory exudate tends either to glue the iris down to the anterior surface of the lens, with which it is normally in close apposition, and to fill the pupil with a mass of inflammatory exudate, which ultimately becomes fibrous, or merely to attach the edge of the iris to the anterior surface of the lens, leaving the pupil clear. These two conditions are given different names. The first, in which the pupil is filled up, is called occlusion of the pupil; the second, in which the pupil remains clear, exclusion. The result of both conditions will be that the aqueous secreted by the ciliary body gets collected behind the iris, and as this is not permeable to fluid, cannot get into the anterior chamber. Not only this, but the iris is pushed forward against the posterior surface of the cornea, blocking the angle the whole way round, and so the exit of lymph to the canal of Schlemm. Therefore, you should remember that any case of iritis in which the pupil is completely blocked by exudate will be followed by glaucoma, unless some means are taken to prevent it.

For the causes of acute primary glaucoma, in which there has not been some primary disease, you have to look for conditions which may tend to obstruct the normal exit of lymph in the angle of the anterior chamber, and of these there are three which are fairly constant. The first is the size of the lens, the second is the size of the eye, and the third is the size of the ciliary muscle itself. All these three factors determine how much space there is to spare in the eye, and they may all tend to block the angle of the anterior chamber. A patient who suffers from hypermetropia has a comparatively small eye, short in its antero-posterior diameter, and often small in other respects, especially in the size of the cornea. The lens, however, is fairly constant in size, and, other things being equal, there is not such a large circumlental space in a hypermetropic as in a myopic eye, and it is an interesting fact that myopic persons seldom suffer from glaucoma. Secondly, in normal people the lens slowly increases in size as the years go on, until in late adult life the lens may take up much more space than in the young adult. It is then much more likely to press the iris forward, especially at the root, and push it against the posterior surface of the cornea, occluding the angle of the anterior chamber. The third factor is the size of the ciliary muscle. The myopic person has a very poorly developed ciliary muscle, which does not occupy much space. The hypermetropic person, on the other hand, who is compelled continually to accommodate to get distinct vision at all distances, has the muscle hypertrophied in consequence. It is often congested and engorged with blood from excessive use, as in people who earn their living by sewing.

Then the last factor which may precipitate an attack of glaucoma is dilatation of the pupil. Here is a diagram of an eye in which the pupil has been dilated with atropine; the iris has been drawn up into a smaller space, so that it is thicker through, and its anterior surface is

in touch with the posterior surface of the cornea, occluding the angle of the anterior chamber. Atropine is, therefore, a dangerous drug to use in doubtful cases, and often the dilatation of the pupil with atropine will start an attack of glaucoma in a person who is predisposed to this condition.

Symptoms.—Now what are the characteristic symptoms of an attack of acute glaucoma? It seldom comes on acutely at first; people usually have warning attacks to which they do not attach much importance, but these ultimately culminate in an attack of acute glaucoma, which nearly destroys their sight in 24 to 36 hours. One of the prodromal symptoms of glaucoma is a certain degree of mistiness of vision, especially at night. People who are using their eyes all day say that as night comes on their sight gets misty, and they may have some difficulty in seeing their way home. They find increasing difficulty in reading or sewing by artificial light, and their vision altogether is bad in the evening. On waking up their sight is better again, and in some cases this cycle recurs daily. Every such attack gets a little worse, and there is increasing pain.

There may also be other symptoms, such as coloured rings seen like rainbows round lights, rapid failure of accommodation or increasing presbyopia, diminution of the visual field, and central or peripheral scotomata.

Then some extra strain upon the eye brings on the acute attack. There is intense pain in one or both eyes, accompanied by violent trigeminal neuralgia, headache, and often severe vomiting. These symptoms are sometimes mistaken for those of a bilious headache, and the patient is treated for this condition, whereas the vomiting and headache are reflex eye symptoms. There is also rapid diminution of sight, the vision falling from normal one day to bare perception of light the next. When the limitation of the field of vision commences, it is usually concentric, but the defect is most evident on the nasal side of the field. The objective symptoms of acute glaucoma are redness and congestion of the eye, engorgement of the conjunctival and deeper ciliary vessels, and extreme tenderness of the eye. The cornea itself is no longer clear and polished, but is grey and hazy like a steamy window, and insensitive to touch. The anterior chamber is shallow, the iris being close to the posterior surface of the cornea. The pupil is semidilated, often oval in shape, and fixed, reacting neither to light nor accommodation, and if there is one symptom more than another which should impress you in glaucoma it is that dilatation of the pupil. In iritis, on the contrary, the pupil is constricted. Within the dilated pupil there is a peculiar greyish-green reflex, almost as if there might be a cataract, though no definite opacity of the lens is to be found, and this characteristic appearance in the pupil is the symptom which first led to the choice of the name glaucoma. Finally, the eye is extremely hard to the touch. In acute glaucoma the symptoms may last for two or three days; at the end of that time they may begin to subside, and in the course of a week or a fortnight all inflammatory symptoms may have disappeared, and the patient seem to have as good vision as formerly. It is, however, never quite as good, and each successive attack leaves it a little worse. If nothing is done, the attacks increase in frequency and severity till ultimately the vision is entirely lost. And even when the patient is entirely blind the disease has not finished with him, because he will still have recurrent attacks of increased intra-ocular tension with severe pain, relief being ultimately obtainable only by the excision of the eye.

Chronic glaucoma differs from acute in that all the symptoms are less severe, and the eye apparently adapts itself more easily to the slow diminution of sight. People, therefore, who suffer from chronic or simple glaucoma often do not notice that they have much failure of sight until the disease has produced such excavation and atrophy of the optic nerves that no operation will repair the damage that has been done.

Treatment—Having a patient with acute glaucoma, what are you to do? There are two methods of treatment, first, by drugs, and secondly, by operation. The treatment by drugs will be devoted to trying to free the angle of the anterior chamber and to allay the engorgement and pain. The drugs which will free the angle of the anterior chamber are those that constrict the pupil, for it is obvious that if dilatation of the pupil tends to block the angle of the anterior chamber, so the drug which constricts the pupil will draw the iris away from the angle and open up a free passage for the exit of aqueous. In many slight cases of glaucoma drugs of this character are successful in stopping or relieving an attack. The two drugs which are most useful for this purpose are eserine or physostigmine, and pilocarpine. Other drugs such as opium or alcohol, which also constrict the pupil, are of use in the treatment of acute glaucoma, in which there may be available neither the means nor the opportunity

for an operation. Hot fomentations and counter-irritation by blisters or leeches are also indicated.

Treatment by eserine or pilocarpine is, however, only a palliative, and the real cure for acute glaucoma is an operation, iridectomy, devised to make a permanent free exit for the aqueous from the anterior chamber into the canal of Schlemm or the subconjunctival space. But the iridectomy must be done with that special object in view, and must not be the ordinary iridectomy as performed as a preliminary to the extraction of cataract. This latter operation is done by making an incision in the cornea at the corneo-sclerotic margin and removing a piece of iris through the incision. The corneo-sclerotic margin externally does not, however, correspond with the root of the iris and the angle of the anterior chamber internally. The angle is further back than the corneo-sclerotic margin, and if an incision is made at this site, and a piece of iris removed, a large portion will be left to block the angle. The incision for iridectomy in glaucoma must therefore be made so far back that it will permit the removal of the iris right down to the root, thus opening the angle of the anterior chamber or even the canal of Schlemm itself. The result of this operation, if successful, is that a permanent exit for the aqueous is made, and the tension rapidly diminishes, and if this is done in the first attack of acute glaucoma a cure is effected in most cases. It is doubtful, however, whether an iridectomy furnishes an absolute cure, for it is to be remembered that glaucoma is a disease of late middle life, and that a large number of people die within ten or fifteen years of the attack; there is, therefore, not much evidence of the vision of patients remaining good for an indefinite period, though it is well known that in many cases such an operation will prevent another attack. On the other hand, if the condition is allowed to develop into that of chronic glaucoma, in which the iris becomes atrophic and friable, and firmly adherent to the posterior surface of the cornea, no amount of iridectomy seems to have any result. You may try and remove the iris in the way I have described, but it tears away, and you cannot clear the angle of the anterior chamber, and any filtration which may be desired is impossible when the iris is atrophic. If the glaucoma has gone on long enough for there to be any cupping of the optic disc, the vision which is lost through the resulting atrophy of the optic nerve can never be recovered, and the disease has already made such progress that it cannot be arrested. Therefore, remember that the prognosis as to sight after iridectomy in acute glaucoma is comparatively good, but bad in cases of the chronic form. Other operations have been devised for the relief of chronic glaucoma by the creation of permanent fistulæ through which there will be leakage of the aqueous from the anterior chamber into the subconjunctival space, but up to the present most of these have proved abortive, the scar filling up with fibrous tissue, which forms an even denser obstruction. Therefore chronic glaucoma, however you treat it, seems to present a problem which we have been unable to solve. At best we can only say that the prospects of iridectomy are hopeful in the earlier stages of the disease. Very often people advanced in life, especially over sixty years of age, if treated with eserine continually for long periods, retain their sight more satisfactorily than if an iridectomy had been performed. Their sight will fail so slowly that it will last them for all useful purposes as long as they live. Finally, may I remind you once again that you should always be watchful for the prodromal symptoms of primary glaucoma, mistiness of vision with slight pain, and limitation of the visual field, and should always keep in mind the importance of differentiating between glaucoma and iritis. The proper treatment for the one is disastrous for the other. But if you are uncertain and you have to make a choice of two evils, you will do much less harm by treating iritis with eserine than by treating glaucoma with atropine.

Change of Address.

W. J. Burroughs, M.R.C.S. Eng., L.R.C.P. Lond., from 25, Welbeck Street, W., to 71, Harley Street, W.

F. C. Endean, M.R.C.S. Eng., L.R.C.P. Lond., from Guy's Hospital to c/o W. P. Endean, LL.B., Victoria Arcade, Auckland, New Zealand.

A. Hammond Smith, L.D.S. Eng., from 70, Wimpole Street, W., to Henley House, 29, Hart Street, Henley-on-Thames, Oxon., and 211, King's Road, Reading.

J. W. F. Jewell, M.D., M.S. Lond., from "Oakmead," Balham, S.W., to "Marmora," 207, Balham High Road, S.W.

H. R. Mullins, M.R.C.S. Eng., L.R.C.P. Lond., from the College, Guy's Hospital, to West Hill, Grahamstown, South Africa.

F. Stanley Wood, M.R.C.S. Eng., L.R.C.P. Lond., from Westbourne House, Sheffield, to Red Lea, Scarborough.

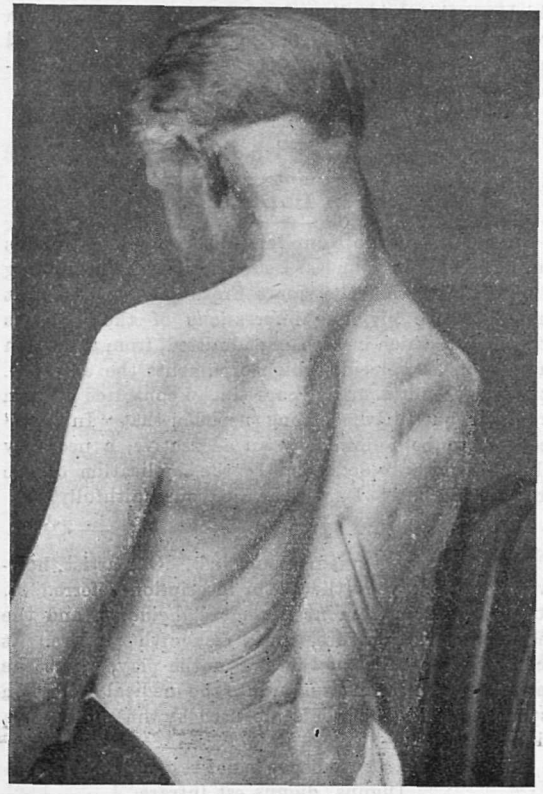
(The Editor will be very glad to receive a postcard with notes of any change of address.)

A Case of Spondylitis Deformans.

Charles I., æt. 61, came up to Dr. French's out-patients in June, 1910, complaining of an increasing stiffening of his neck and back. His condition had been getting steadily worse for the past twelve months. Some six months previous to this he had consulted his doctor for "pains in the back and difficulty in stooping." He was treated with salicylates and iodide of potassium, and within three weeks the pains had quite disappeared.

At this time his head was quite erect, and there was no evident curvature of the spine. It may be said that the man had always enjoyed perfect health, that there was no family or personal history of rheumatism, and that his work as a gardener entailed an out-of-door life.

Some eighteen months after the onset of his symptoms, the patient was seen by Dr. French, who considered the man to be suffering from Spondylitis Deformans. His condition at this time (shown in the accompanying photograph) was as follows:—He was quite unable to extend the



head, but kept it always in a flexed position; the normal cervical curve was thus entirely obliterated. The dorsal curve with its concavity forwards, was normally present. All movements of the spine, however, were made in the lumbar region, as could be seen when the patient was asked to bend forwards, the dorsal curve maintaining its fixed position and the lumbar spines alone showing relative movement. This showed that the ankylosis of the intervertebral joints, which at first involved the cervical vertebræ only, had now affected those in the dorsal region.

The limited movement of the head was the patient's chief complaint. Though the rotatory movements were fairly free, the nodding movements were greatly restricted and very painful. This showed that the atlanto-axial joints, responsible for the rotatory movements, had as yet escaped ankylosis, but that changes had already occurred in the articulation of the skull upon the atlas, either an ossification of the ligaments connected with the joint, or a definite ankylosis of the articular surfaces.

The patient's chest was flattened antero-posteriorily to a remarkable extent. His breathing was almost entirely diaphragmatic. There was a difference of but one-tenth of an inch in the circumference of his chest at inspiration and expiration. This showed that changes, similar to those that had earlier affected the intervertebral joints, had taken place in the costo-vertebral joints, causing them to become ankylosed.

The man himself was of rubicund countenance, his general health being of the best and his appetite excellent. He was employed as a permanent labourer upon a farm. His heart and viscera generally were sound and his urine normal.

The patient was skiagraphed to discover what bony changes had taken place in the cervical region of the spine. The following report was sent in by Dr. C. J. Morton:—A lateral view of the neck shows much alteration in structure of all the cervical vertebræ. There is irregularity from thinning and destruction of bone, and in addition, considerable deposits of fairly translucent material. The sixth and seventh vertebræ are most affected; there is a curious rigid appearance of all the spinous processes, and a concavity forward due to destruction of the bodies. The anterior common ligament appears thickened.

The case bears a remarkable resemblance to one described by Dr. C. Hilton Fagge, in *Trans. Path. Soc.*, 1877, and one which he considered to be unique. The patient in this case was a man of 34, with a fixed kyphosis of his dorsal curve, almost complete inability to move his head, and a flattened chest. This is of especial interest, as it is one of the few instances in which a post-mortem examination of a patient having this disease has been recorded. The examination showed that the spines were firmly united by bone; bony ankylosis was present between the articular joints; the bodies had undergone rarefaction with occasional spaces where the destruction had been more complete. The ribs were firmly united to their corresponding vertebræ, not only by the head, but also by the tubercle.

It was particularly noted that none of the bony nodular osteophytic changes, so characteristic in cases of osteo-arthritis, were present.

Of the treatment little need be said. The progressive nature of the disease limits the physician to improving the general condition of the patient by dieting and fresh air. Hot-air treatment is undoubtedly beneficial, and the hot-springs at Bath are said to have given good results.

C. WARNER.

London University Officers' Training Corps.

The section of the London University Officers' Training Corps in connection with Guy's Hospital is the "B" Section of the Medical unit, and includes men from Guy's and St. Thomas's. Students who have already been in their school corps can transfer to this section, and if they have done certificate "A" it still holds good. Those who have never been in any corps before should join as recruits, and must work hard in the early part of the year to learn their squad and company drill in order to be ready to learn their ambulance and other drill as the summer approaches. Membership of the corps entails putting in a certain number of drills during the year, which can easily be done, and also attendance at the annual inspection and the fortnight in camp during the summer. Anyone who thinks he may be likely not to want to come to camp in the summer had better not join. There will be but a limited number of vacancies in the section depending on the number of men now in the corps who are rejoining. Names should be given in to Lieutenant Layton either in the dissecting room on the morning of Tuesday, October 4th, or in the Biology class-room on Wednesday, October 5th. Men wishing to rejoin may give in their names at the same time.

Guy's Choral Society.

The first practice of the Choral Society will be held in the Committee Room on the second Friday in October. The attention of men coming up this October for the first time is especially drawn to this Society. Two concerts are given every winter, one before Christmas, and one in the spring. The rehearsals are held every Friday at five and eight o'clock. There is no subscription, and all men who can sing, or would like to try, are very welcome. Men in the Dissecting Room or the Physical and Chemical Laboratories can obtain all information from O. Parry-Jones, Dental Students from W. H. Lakeman, Students in the Wards from the Secretary. All notices are posted in the Dissecting Room, the Conservation Room, and on the screens opposite the door of Astley Cooper.

L. C. DUNDAS IRVINE, Hon. Sec.

Correspondence.

To the Editor of Guy's Hospital Gazette.

Improvements in the Students' Club.

Dear Mr. Editor,—May I ask you to call the attention of members of the Students' Club to an attempt which is about to be made by the Committee to rid the staircases of the Club from their daily accumulation of hats, coats, and handbags. The College Committee has generously fitted up cloak-room accommodation in the basement which should be amply sufficient for our purpose.

The Committee has given instructions to the Club boy to remove all articles lying about to the cloak-room, where they will be found in the recess under the staircase. For many years the chief drawbacks of the Club have been the want of sufficient cloak-room accommodation and of sufficient lavatories. The College Committee has generously remedied both these defects during the past year. The greatly improved appearance of the Library we owe to the Clubs' Union, which has given a special grant for the purpose. This room, in which smoking is allowed, should now be of much greater use to the Club than it has been in the past, and should help to relieve the overcrowding in the smoking-room.—I am, yours very truly,

H. CHARLES CAMERON.

6, St. Thomas's Street, S.E.,
Sept. 27th, 1910.

A Point in Latin Grammar.

Dear Sir,—While complimenting your artist on his clever drawing in your last issue, I cannot help thinking it unfortunate that the smart Freshman depicted in it should receive his first impressions of the "Corpus doctum," to which he is being admitted, from the Latin inscription of welcome which ornaments the entrance. It is true that it is many years since I consulted a Latin grammar, but I have a strong suspicion that "Intrare" requires to be followed by an accusative, a necessity which is not avoided even by the duplication of the preposition "in."—I am, dear Sir, yours faithfully,

W.

["W.'s" criticism is no doubt just. Our artist, however, did not invent the Latin inscription referred to, but borrowed it from *Le Malade Imaginaire*, and the responsibility, therefore, must rest with Molière. It occurs in the ballet at the end of the play, where the ceremony of initiating a man into the medical profession is burlesqued. The words are used by the chorus as a kind of refrain:—

"Bene, bene, bene, bene, respondere:
Dignus, dignus est intrare
In nostro docto corpore."

Molière probably wished to parody the dog-Latin affected by the medical men of his day, along with their other absurdities and eccentricities.—Ed., G.H.G.]

To a Skeleton.

I.

Oh! bones bereft of all the nice warm raiment,
Wherewith Dame Nature formerly did clothe you,
Will you accept these verses as part payment
From one, who, though he'd sometimes cause to loathe you?
And *though before his thanks he's seldom* tendered,
Yet in these hours of easy inanition,
For all the services which you have rendered,
Desires to show some signs of recognition.

II.

Ah! sphenoid, carpus, os innominatum,
What a dull drudgery it was to learn you.
Well I remember thinking, "How I hate 'em!"
But now I'm "through," I'll be the last to spurn you.
Here in a huddled heap though you are fated
To spend your days unhandled and unheeded,
Remember that the learning you instated,
Will not be wasted, only superseded.

III.

Whate'er your trade was in your pre-existence,
Sweeper of crossings, or a poet-dreamer,
(Perhaps you even offered stout resistance
In cup-ties, with that tibia and femur);
Whate'er you did then, sir, when you were mortal,
And though you now have few scholastic features,
Anatomy, which you've so ably taught'll
Grant you the honoured place among her teachers.

IV.

Now though your story has been fully written
In Gray's and other unengrossing pages,
I must confess to feeling conscience-smitten
That you should only be discussed by sages;
And therefore I, who recognize and know it,
Have taken on myself (all unrewarded)*
This task of panegyrist and—er—poet,
Lest your ossific worth should pass unlauded.

V.

Your hand then, sir, or rather, let me clasp your
Manly metacarpals ere we part, sir;
Though of your details I may loose my grasp, your
Looks at least shall linger in my heart, sir.
Farewell awhile; perchance in days far future,
On Stygian shores we may arrange a meeting.
I shall not fail to mark each friendly suture,
Nor yet, I hope, to give you ghostly greeting.

R.

Reviews, etc.

Books for review should be addressed to The Editor, Gazette Office, Guy's Hospital, S.E. Their price should in every case be stated.

Fractures and Separated Epiphyses. By Albert J. Walton, London. Edward Arnold, 1910.

This aims at being "a small book dealing with the more practical aspect of fractures." Fractures of the skull and spine are purposely omitted. The book has much to commend it. An attempt is made to deal with the prognosis of the various fractures, a matter which is neglected in many text-books. Although reference is made to most of the recent work on fractures, the teaching is generally orthodox or even conservative. The subject-matter is chiefly illustrated by new radiograms, which have a far greater claim to accuracy than conventional drawings. The printing, paper, and binding are quite good.

With regard to the general treatment of fractures, the views of Lucas Championnière—early movement and massage with a minimum of retentive apparatus—and Mr. Lane—open operation and fixation by plates and screws—are fairly presented; and the usual lines of treatment by splints are given in greater detail. The description of the application of a Croft's plaster differs from the method used at Guy's, and does not specially commend itself.

Although the work is intended to be of a practical nature, the subject might have been rendered more interesting by a further consideration of the general principles involved. It is also a pity that, whilst two

* Is this a hint?—Ed., G. H. G.

pages can be devoted to the very rare phenomenon of fat embolism, bedsores and splint sores do not appear in the index, and are barely alluded to in the text.

The Legal Relations of Hospitals: Their Staff and Patients. By Digby Cotes-Preedy, M.A., LL.M., L.S.A. (Dissertation approved for the degree of LL.M. in the University of Cambridge.) Sweet and Maxwell, Ltd. Price, 1s. net.

This is a summary of the more important points in the legal relations of hospitals to their patients which have been raised in actions decided in the English and American Courts. In most cases the actions have been brought by patients against hospital authorities for injuries alleged to have been caused by the negligence of the hospital staff. A recent case which attracted a good deal of attention was Hillyer v. Governors of St. Bartholomew's Hospital (1909), in which it was laid down in the Court of Appeal, upholding the decision of Grantham, J., in the lower Court, that the relationship of master and servant does not exist between a hospital and its physicians and surgeons, and that therefore a hospital is not responsible for injuries due to the alleged negligence of the latter, provided it can be shown that due care has been exercised in their selection; also that, though nurses and porters are for most purposes (under the Workmen's Compensation Act, for example) the hospital's servants—while assisting at an operation they cease to be under the orders of the hospital authorities, and are at the disposal and under the sole orders of the operating surgeon during the whole time of the operation. The reason why the medical staff of a hospital are not to be considered its servants is indicated by a definition of servant, such as that of Lord Bramwell: "A servant is a person subject to the command of his master as to the manner in which he shall do his work." The author points out that the position of the anæsthetist is at present undefined. He is certainly not under the control of the hospital authorities during an operation, and they are therefore not responsible for his negligence at such a time; whether or not the operating surgeon would be so responsible is a question that has been much discussed, but never yet determined by a judicial decision.

Cunningham's Manual of Practical Anatomy. 4th Edition, revised by Professor Arthur Robinson. (Henry Frowde, and Hodder & Stoughton.) Two vols. Price, 10s. 6d. net. each.

To none of his text-books, probably, is the student more attached than to his "little Cunningham," if only for the sake of that famous passage where the dissector is instructed to stop work for three days! Joking apart this two-volume manual, with its admirable illustrations, has really no rival as a guide to the student for his work in the dissecting room, and in after years it is still his most valuable ally when he is revising his anatomy for the purpose of his surgery finals.

Appointments.

Medical School Appointments.

The following appointments have been made by the Treasurer upon the recommendation of the Medical Council:—

October—December, 1910.

Clinical Assistants.—Messrs. A. Neville Cox, F. A. Dick, H. W. Doll, G. Maxted, G. Y. Thomson, C. C. Tudge.

Clinical Assistants in Medical Out-Patients.—Mr. W. E. Levinson (Drs. Fawcett and French). A. L. Gardner (Drs. Beddard and Hertz).

Dressers in the Throat Department.—Messrs. H. W. Barber, A. M. Bodkin, H. T. Depree, A. L. Gardner, H. L. S. Griffiths, R. Montgomery.

Medical Ward Clerks.—Extensions.—Messrs. F. C. Hunôt, J. P. Jones (Dr. Hale White); F. C. Newman, V. F. Soothill, E. Lawrence Jones (Dr. Pitt); C. Warner, C. Worster Drought, H. C. Godding (Sir C. Perry); R. S. Kennedy, J. M. Joly (Dr. Shaw). First three months.—Messrs. A. G. H. Moore, J. L. Percival, G. E. Genge-Andrews, S. Keith, G. W. King, J. S. Lauder, C. H. G. Pochin, G. A. Pratt, A. B. Danby, G. S. Miller, W. Robinson, H. C. Rook, A. L. Shearwood, W. L. Webb, J. F. G. Richards, W. K. Fry, L. P. Harris, W. C. D. Maile.

Assistant Surgeons' Dressers.—Messrs. W. Matthews, H. J. Hoby, T. I. Bennett (Mr. Steward); K. B. Clarke, S. Wickenden, J. L. D. Lewis (Mr. Fagge); O. R. L. Wilson, L. B. Stringer, M. Scott, R. D. Passey (Mr. Rowlands); H. Webb, E. C. Cline, W. Whitworth (Mr. Turner).

Surgical Ward Clerks.—Messrs. A. S. Erulkar, V. Atienza, R. Creasy, R. O. H. Jones, G. D. Eccles, J. A. Ryle, C. Sherris, A. J. E. Smith, A. M. Zamora, A. C. Clifford, R. A. Fawcus, N. Garrard, F. A. Hampton, D. W. John, E. G. Martin, J. A. Martin, W. H. Ogilvie, R. C. Ozanne, D. V. Pickering, W. R. Reynolds, A. Wills.

Post-mortem Clerks.—Messrs. H. L. James, A. C. Jepson, G. Covell, P. J. Monaghan, C. Aldis, A. S. Seabrooke (October 1st); H. L. Hopkins, F. Cook, E. G. Schlesinger, A. H. Birks, P. Smith, J. L. M. Symns (November 16th).

Clerks in the Skin Department.—Messrs. H. C. Godding, G. Marshall.

Clerk in the Light Department.—Mr. L. Mandel.

Aural Surgeon's Dressers.—Messrs. B. Blackwood, G. A. Blake, W. T. Chaning Pearce, J. Pryce Davies.

Obstetric Dressers.—Messrs. H. P. Warner, C. Marshall, E. W. Blake, C. M. Ryley, G. W. M. Andrew, L. C. D. Irvine (Mr. Targett); G. T. Foster-Smith, F. G. Lloyd, B. R. Parmiter, H. T. Depree, T. E. Roberts (Mr. G. B. Smith).

Clerks in Electrical Department.—Messrs. F. Cook, E. G. Schlesinger, H. L. Hopkins.

Sport.

Football Fixtures for 1910—1911.

RUGBY.—First Fifteen.

Date.		Club.	Ground.
1910.			
Oct.	1	Old Blues	Home
	8	Catford Bridge	Away
	15	Rosslyn Park	Away
	22	U.C.S. Old Boys	Home
	26	Cambridge University	Home
	29	Lennox...	Home
Nov.	5	Streatham	Home
	9	Oxford Uuiversity	Home
	12	London Welsh	Home
	19	London Irish	Home
	26	Harlequins	Home
	30	United Services	Home
Dec.	3	Northampton	Away
	10	Richmond	Away
	17	Bedford	Home
	24	Marlboro' Nomads	Home
	31	Catford Bridge	Away
1911.			
Jan.	7	Rosslyn Park	Home
	14	Blackheath	Away
	21	Old Merchant Taylors	Home
	24	Oxford University	Away
	28	London Scottish	Away
Feb.	4	United Services	Away
	11	London Welsh	Away
	15	Cambridge University	Away
	18	Old Leysians	Away
	25	Old Alleynians	Away
Mar.	4	Lennox	Away

Second Fifteen.

1910.			
Oct.	1	Borough Road College	Away
	8	Old Charltonians	Home
	15	London Irish "A"	Home
	22	African Banks	Away
	26	Tonbridge School	Away
	29	Chartered Banks	Away
Nov.	2	R.M.A. Woolwich	Home
	5	Streatham "A"	Away
	12	Aldershot Command...	Away
	19	Tonbridge Town	Away
	26		Away
Dec.	3	London Scottish "A"	Away
	10	Rosslyn Park "A"	Home
	17	Marlborough Nomads "A" ...	Away
1911.			
Jan.	7		Away
	11	Royal Veterinary College	
	14		Away
	18	Aldershot Command...	Home
	21	Rosslyn Park "A"	Away
	28	Harlequins "A"	Home
Feb.	4	Old Merchant Taylors "A" ...	Home
	11	R.M.A. Woolwich	Home
	18	Lennox "A"...	Home
	25	Blackheath	Away
Mar.	4	Borough Road College	Home

ASSOCIATION.—First Eleven.

Date.		Club.	Ground.
1910.			
Oct.	1	Old Aldenhamians	Home
	5	Trial Game	Home
	8	Reading Amateurs	Home
	12	Trial Game	Home
	15	Beckenham	Away
	22	Crouch End Vampires	Home
	26	Emeriti	Home
	29		Away
Nov.	5	Old Cranleighans	Home
	12	Old Carthusians	Home
	19	Bank of England	Away
	26	Carshalton	Home
	30	Casuals	Home
Dec.	3		Home
	10	Old Malvernians	Home
	17	Eversleigh	Away
1911.			
Jan.	7	Beckenham	Home
	14	Lancing Old Boys	Home
	21	Bank of England	Home
	25	Emeriti	Home
	28	Eversleigh	Home
Feb.	1	Casuals	Home
	4	Crouch End Vampires	Home
	11		Home
	18	Carshalton	Away
	25	Old Felstedians	Home
Mar.	4		Away
	11	Parthians	Away
	18	Aquarians	Away
	25	Reading Amateurs	Away

Second Eleven.

1910.			
Oct.	5	Trial Game	Home
	8	Surrey Cup	
	12	Trial Game	Home
	15	Beckenham Reserves	Home
	22	Crouch End Vampires Reserves ...	Home
	29	Old Staffordians	Home

Nov. 2	University College Hospital	...	Home
5	Old Cranleighans "A"	... ...	Home
12	Bexley	...	Away
16	St. Thomas' II.	...	Away
19	Bank of England Reserves ...	...	Home
26	Carshalton Reserves... ...	...	Away
30	Brentwood School	...	Away
Dec. 3	Foxes	...	Away
7	St. John's College (Battersea)	...	Home
10	University College Hospital	...	Away
17	Eversleigh "A"	...	Home
1911.			
Jan. 7	Beckenham Reserves ...	...	Home
14	Bank of England Reserves ...	...	Away
18	St. Thomas' Hospital ...	...	Home
21	Eversleigh Reserves	...	Away
25	St. John's College (Battersea)	...	Away
28	Old Grammarians Reserves	...	Away
Feb. 1	Brentwood School	...	Away
4	Crouch End Vampires Reserves	...	Home
11	Old Cranleighans Reserves ...	...	Home
18	Carshalton Reserves... ...	...	Home
25	Camberwell Grammar School	...	Away
Mar. 4	Old Quernmorians	...	Away

Appointments.

Civil.

Broderick, C. C., L.R.C.P. Edin , has been reappointed Medical Officer of Health of Tavistock, Devon.

Naval and Military.

Fleet-Surgeon Percival M. May, R.N., has been appointed to the *Glory* and for special service vessels, and Surgeon F. R. Featherstone, R.N., to the *Victory*, additional, for disposal.

An exchange of positions on the roster of Foreign Service has been approved by the War Office between Major S. M. Fairrie, R.A.M.C., Shorncliffe, and Major C. M. Fleury, R.A.M.C., serving at Tidworth. Captain F. M. M. Ommanney, R.A.M.C., has been selected to succeed Captain B. S. Bartlett, R.A.M.C., as Company Officer at Colchester.

THE EDITOR will, at all times, be glad to consider Articles or sketches, provided that they are accompanied by the writer's name and address, not necessarily for publication. Payment is a matter of arrangement, and the fees that the Gazette *can offer are merely nominal, but if the writer desires any remuneration that fact should be stated. Authors who desire reprints of their papers should make their own arrangements with the printers when they return their proofs.*

Papers by Guy's Men.

J. H. Badcock, L.D.S., M.R.C.S. Eng., L.R.C.P. Lond.: The Need for Correction of Malposition of Teeth.—*British Medical Journal*, 17th September, 1910.

E. Rowland Fothergill, M.B., B.S. Durh.: State Invalidity and Sick Insurance.—*Ibid.*

Kenneth Goadby, M.R.C.S., D.P.H. Lond.: The Buccal Secretions and Dental Caries.—*Ibid.*

T. D. Lister, M.D. Lond., M.R.C.P. Lond., F.R.C.S. Eng., and W. D. Wilkins, M.B., Ch.B. Vict., M.R.C.S. Eng., L.R.C.P. Lond.: The Benenden Sanatorium and Industrial Insurance for the Treatment of Phthisis.—*The Lancet*, 17th September, 1910.

Laurie McGavin, F.R.C.S. Eng.: Remarks on Eighteen Cases of Spinal Analgesia by the Stovaine-Strychnine Method of Jonnesco, including Six Cases of High Dorsal Puncture.—*British Medical Journal*, 17th September, 1910.

William Sheen, M.S. Lond., F.R.C.S. Eng., H. A. Scholberg, M.B. Lond., D.P.H. Camb., and R. L. Mackenzie Wallis, B.A.: A Case of Chondro-Carcinoma of the Testis (Illustrated).—*The Lancet*, 17th September, 1910.

Periodicals Received.—The Hospital, The Clinical Journal, The Calcutta Medical Journal, The Manchester Medical Students' Gazette, St. George's Hospital Gazette, The Nursing Times, The Polyclinic, South African Medical Record, The Stethoscope, The M.S. Journal, The Prescriber, New York State Journal of Medicine, Annual Summary of Observations made at the Meteorological Station, Davos, The Middlesex Hospital Journal, St. Bartholomew's Hospital Journal, Annual Report of the Earlswood Asylum.

Birth.

HANDLEY.—On September 10th, at 12, New Cavendish Street, W., to Mr. and Mrs. W. Sampson Handley, a son.

Marriage.

GRAHAM-SMITH—LEITH-ROSS.—On September 8th, at St. Mary's-on-the-Rock, Ellon, Aberdeenshire, G. S. Graham-Smith, M.A., M.D. Cantab., to Violet, only daughter of Colonel Leith-Ross, of Arnage, Aberdeenshire.

Deaths.

LAW.—On September 6th, at Bournemouth, after an operation, William Thomas Law, M.D. Edin., F.R.C.S. Eng., aged 65 years.

TURNER.—On September 14th, at Steyning, Henry Crockford Turner, M.R.C.S., L.S.A., aged 61 years.

Ed.—A. N. C.

GUY'S HOSPITAL GAZETTE.

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Passim.

WE are asked to announce that the first ordinary meeting of the Physical Society will be held this evening (Saturday), and will be a Pathological meeting. The Society's programme for the session has just been published. It includes, we notice, a discussion on "Faith Healing, or the Mental Factor in Disease," which Dr. Craig is to open, and at which Drs. Beddard, Boycott, and Hertz, and Mr. Thompson are expected to speak. As this is a subject which is of more importance, perhaps, in private practice than in hospital work, it is to be hoped that old Guy's men who are in general practice will come to the discussion and give the members the benefit of their experience.

THE results of the recent examinations for Entrance Scholarships have been announced as follows:—Senior Science Scholarship: £50; Ronald C. Ozanne, B.A., Hertford College, Oxford; Junior Science Scholarships: £150, Arthur Lisle Punch, Preliminary Scientific Class, Guy's Hospital; £60, Alfred G. Simmins, Guy's; Certificates: John Frank Herbert Stallman, Guy's, Olaf Gleeson, Walthamstow Technical Institute: Entrance Scholarships in Arts: £100, Alexander Beckett Bond, Bradfield College; £50, John Arnold Molony Alcock, Radley College; Equal Certificates: Samuel Vidot, St. Louis College, Seychelles, Albert Victor Wood, Wolverhampton Grammar School. It is worthy of note that Mr. Alcock gained the second Entrance Scholarship in Arts in spite of the fact that he was absent, on account of illness, from one of the examinations.

AT the recent conversazione of the Physical Society, notices were posted on the doors of the Museum requesting that gentlemen should not smoke in the Museum on account of the great inflammability of the contents. That this should have been thought necessary illustrates the thoughtlessness with which many men regard the rule against smoking in the Museum. From our own experience we have found that most men regard that rule simply as one of the vexatious restrictions which persons in authority invent as a hobby. As a result, the rule has been, and is still occasionally, disregarded. But we feel sure that when men using the Museum once realise the disastrous consequences which would almost certainly follow an outbreak of fire in the Museum, they will respect it. It is not difficult to imagine how a small fire breaking a single specimen bottle filled with spirit would rapidly spread to other bottles, breaking them in turn; and how in half an hour the whole collection, which is the accumulation of years and years, might be destroyed. No risk such as this can be covered by insurance. Small wonder, then, that the authorities rigorously apply the rule against smoking, which is the commonest cause of outbreaks of fire, and they have a right to expect

that the men will see with them in this matter. There are so many other places about the hospital where smoking is permitted, or at any rate not forbidden—too many, some people think—that nobody can make the Museum rule into a grievance.

A death under particularly distressing circumstances was that of Dr. Walter Strover, M.R.C.S., an old Guy's man practising in Hoxton. About three weeks ago, on the 21st September, he disappeared suddenly from his home, after having attended to a number of patients who had called during the morning, and nothing was known of his whereabouts until last Friday, when his body was discovered in a wood at Sandy, near Biggleswade, Bedfordshire. Dr. Strover's wife was a cripple from paralysis, and it is supposed that the more serious turn which her illness had taken preyed upon his mind. She died while he was still missing, and information as to the discovery of his body was received from the Bedfordshire police shortly before the time of her funeral. An inquest on the body of the late doctor was opened last Saturday, and adjourned, after evidence of identification had been given, until the 14th inst. Dr. Strover, who was 56 years of age, and received his medical education at Guy's, had an unusual career. After building up a good practice and holding the post of medical officer of health for Chingford, he relinquished both, and other appointments, in order that he might devote all his time and attention to the poor of North London. There, in Hoxton, it is said he sacrificed a fortune in this noble work, often refusing fees even in cases where he ought to have taken them. Thus he earned, and gained, the love and respect of thousands of poor patients. His was a practical carrying out of ideals which is as rare as it is difficult in our modern world. To his relatives we extend our sincere sympathy in their sudden double bereavement.

On another page of this issue will be found a short article explaining the meaning and method of carrying out the Wassermann reaction. The workers in the Bacteriological department have found themselves latterly almost besieged by inquiries from students, residents, and others as to the details of this latest diagnostic weapon, and we are therefore publishing this article in order that all the inquirers may be answered at once. In all probability the Wassermann reaction will soon find its way into examination papers, if indeed it has not done so already, and the article may therefore be of use to men who are in the happy position of preparing for examinations, especially as the original papers and books in which the reaction is discussed do not commonly come under the notice of the average student.

The "Borough."

THE new student just starting his course at Guy's finds himself coming in touch with a part of the world which is probably quite new ground to him. He may have had a vague knowledge that there existed a part of London called the Borough, he may have heard of Southwark and Bermondsey (a bye-election, for instance, sometimes brings a place temporary fame), and though very probably the name of Guy's was much more familiar to him than these names, he may never have had any clear idea as to its situation on the map of London. Of the thousands who daily cross London Bridge on their way to or from the great railway stations, how few know anything about the district through which they pass so often. In coming up to town in the morning, when the train pulls up for a time—out of sheer cussedness, just short of the station—they look out of the carriage window, and see only a field of chimney-pots, and perhaps, in the distance, a taller growth of masts. It is just an unintelligible maze of streets which they suppose have names, houses which they suppose have occupants, but they think no more about it, and return to the study of their newspapers. If they happen to have been Guy's externs, however, it is a different matter. The streets which the great railway crosses so unconcernedly have names familiar to them, beneath the chimney-pots the houses contain a multitude of inhabitants of every kind, for they know it by personal experience.

The student who has not been "on the district," and does not live in the College, possibly knows little more about the purlieus of the hospital than the City clerk whom we have imagined crossing London Bridge. He knows, of course, St. Thomas's Street and Maze Pond, but little else, for he has taken his part in the great movement of living a little way out of

London, and coming up every day by train, or tube, or bus. Very likely he lives at Honor Oak Park, so as to be close to his ground for games; or he lives at Brockley, or Lee, or Blackheath, or still further afield, down in Kent or Surrey, drawn from London by the lure of fresher air, newer and cleaner houses, open spaces to breathe in.

It was not always so. The Guy's student of the last century lived near his hospital, in such rooms as he could find. Several of the streets and squares in the neighbourhood, fallen from their eighteenth century dignity as the houses of City merchants, were occupied almost entirely by "diggings" for students. Bob Sawyer, accepted as the type of the medical student the world over, lodged, while pursuing his studies at Guy's, in Lant Street, leading off the Borough High Street, where Dickens himself, as a boy, had lived during the time that his insolvent father (the prototype of Micawber) and family were in the Marshalsea Prison close by.

The student who decides to live in the neighbourhood of the hospital, or has the curiosity to explore the by-ways of Southwark and Bermondsey, will find that there are many historical and literary associations which give a new interest to the mean streets. He may see, for instance, in imagination, the maze of wharves and warehouses, slums and block-dwellings cleared away, and in their place a piece of low marshy ground with one highway leading up to the earliest London Bridge, protected on the South side by the South *wark*, or fortification, while lower down the river is the *ey*, or piece of land intersected by creeks, belonging to Beormund, an Anglo-Saxon lord. Later, this bridge, which, it is quaintly said, "was so wide that if two carriages met they could pass each other," was destroyed by King Olaf of Norway (afterwards canonised and remembered by the church near by), who was allied with Ethelred the Unready against the Danes who held London. A succession of London Bridges followed, each taking its part, and no small one, in history, until the present one was opened in 1831. One of the porches removed from the old bridge stands in the hospital grounds, and is an object of interest shown to visitors. The history of London Bridge alone might be made to occupy a volume, so that we can only here recommend the reader to turn to the fascinating pages of Besant's "South London," if he would learn more about the historical associations of the district.

Three great names in literature which overshadow all others have close associations with the Borough. Who can forget that Chaucer's immortal pilgrims started on their journey from the old Tabard Inn, which formerly stood in the Borough High Street, but was burnt down in 1873? With its fellows, the White Hart, the Catherine Wheel, and others, this old inn has been replaced by ugly modern liquor shops, defaced by all the gilded tawdriness which seems to be associated with the sale of alcohol, or by busy railway goods yards, of none but utilitarian interest. One precious fragment of these old inns remains—a part of the old George, standing in the Great Northern Railway yard, off the Borough High Street, reminiscent of old coaching days, and eagerly sought out by lovers of the picturesque.

If Chaucer's name is recalled by these old inns, not less is Dickens's. Dickens, indeed, has cast a glow of romance over many parts of the district. Bob Sawyer's Lant Street lodging has been referred to. Sam Weller's first meeting with his famous master took place in the White Hart Yard. Little Dorrit was born in the Marshalsea, which stood near the spot now known as Angel Court, off the High Street. Bill Sykes' last great struggle for life took place on Jacob's Island, on the river side of Bermondsey. No part of London has richer associations with Dickens. Modern Borough Councils have recognised this in going to his works for their street names, such as Quilp Street, Tupman Street, and so on.

The third great name is Shakespeare, who dwelt for some years in a narrow street near St. Mary Overie, the church now known as Southwark Cathedral, and there wrote many of his plays. They were acted at the neighbouring Globe Theatre, (the "cockpit" and the "round O" referred to by Chorus in *Henry V.*), of which he was one of the proprietors. Controversy has recently raged as to the exact site of this old

playhouse, but it is generally agreed that it was somewhere about the position of Barclay and Perkins' huge brewery, and on the outer wall in Park Street of that ugly and imposing building the London Shakespeare Reading Society last year placed a bronze tablet, in memory of the dramatist and of the theatre. Many other playhouses, such as the Rose, the Hope, and the Crown, stood in the same neighbourhood in Elizabethan times, and here in later years were the bull and bear-baiting rings, and a resort of doubtful reputation called the Paris Garden. Other great dramatists besides Shakespeare lived here—Massinger, Middleton, Fletcher, and windows to their memory may now be seen in the Cathedral, together with one to Shakespeare's brother Edmund, the actor.

Such are some—the merest suggestion—of the literary and historical associations of the Borough. To some people they convey a vivid meaning; to others, who live wholly in the present, history is but a collection of dry bones, best left undisturbed as far as they are concerned. The latter may see in the present and its problems the most interesting study. In the Borough, then, they may study many problems — drink, poverty, unemployment, sweating, moral deterioration, criminality. All these at one time or another present themselves in the hospital wards or Out-patient Departments, coupled with broken limbs, or heart disease, or some other physical infirmity, and the one has to be studied and treated as well as the other. At the same time the field for the study of human nature is so great, and none but the dullest pedants refuse to be students of that subject, and to note, for instance, the class distinctions among the poor, as subtle as any in "Society;" their luxuries and necessities, often so strangely different to what one would have imagined; their generosity and enmity to neighbours; the survival of some of the most delicate traits of human character among surroundings of physical degradation.

To others, again, the life of the present in a district like this is merely ugly and sordid. They see in the well-meaning endeavours of Borough Councils, Hospitals, Members of Parliament, Poor Law Officers, "Settlement" Workers, Missionaries of Socialism and Anti-Socialism and every other political cult, Police Court Officers, School Teachers, and Medical Officers, organised charitable associations and unorganised—attempts of flies, often working in opposite directions, to alter the course of the great engine of human life. They look forward, perhaps, and see a visionary Borough of the future, where disease and dirt and poverty shall have been replaced by health and cleanliness and prosperity. For our part, we can see but little in that direction, and nothing clearly. To others of a like mind, we commend the study of history, teaching, as it does, how To-day, which is often so obscure, is explained by and dependent upon Yesterday.

Appointments.

Civil.

Morgan, D. L., M.D. Lond., M.R.C.S., L.R.C.P. Lond., has been appointed Certifying Surgeon under the Factory and Workshop Act for the Pembroke District of the County of Pembroke.

Peall, G. H., M.B., B.S. Lond., has been appointed Surgeon to Lomagunda District, Southern Rhodesia.

Naval.

Fleet-Surgeon W. W. Pryn, R.N., has been appointed to Haslar Hospital for instruction of Surgeons on entry.

Surgeon F. G. Goble, R.N., has been appointed to the *Minerva*, on recommissioning.

Staff-Surgeon S. S. H. Shannon, R.N., has been allowed to withdraw from the Service, with a gratuity. He was appointed Surgeon June 9th, 1902, and became Staff Surgeon June 9th, 1910.

Sir Alan Reeve Manby, M.V.O., has been appointed Physician Extraordinary and Surgeon Apothecary to Queen Alexandra's Household at Sandringham.

From the Gazette's Special Pathologist.

R. I. N. B., Harwich.—Smear preparations of this discharge show a small number of squames and pus cells with much cellular detritus. A fair number of micrococci are seen to be present, and media inoculated yield mixed cultures of a streptococcus showing long chain formation, a white staphylococcus, and an occasional colony of the staphylococcus pyogenes aureus. Please advise us by return if you wish the cultures kept with a view to treatment by vaccine.

H. J. H., Amersham.—Blood serum, inoculated with his swab, gave, after incubation, a culture containing micrococci, but no Klebs Loffler bacilli were found.

PATHOLOGIST.

The Physical Society's Conversazione.

In place of the dinner and address which have been held in recent years at the opening of the Physical Society's season, the older custom of holding a conversazione was revived, and we consider that the experiment was amply justified by its result. The function was held on Friday, October 7th, in the Medical School Buildings. In spite of the fact that these buildings are still in a process of evolution in the builder's hands, it was evident that the improved buildings will be much better adapted for an occasion of this sort, as well as for their ordinary every-day uses, than the old. The new steps and entrance hall leading to the building in particular are a great improvement on the old. On Friday night the library, museum, and several of the laboratories were in use.

It gives us very great pleasure to be able to record that the honoured president, Sir Samuel Wilks, was again present at a meeting of the society in which he has taken so much interest. Supported by the hon. vice-presidents—Drs. Pavy, Goodhart, Taylor and Savage—the hon. president received the guests in the Wills Library. In spite of his years, Sir Samuel appeared to be in good health, and he chatted with many of the visitors, telling us some reminiscences of his early days at Guy's, and of the great men who were his predecessors and contemporaries. He had also brought with him to show us his diploma of qualification from the College of Surgeons, dated 1847, and signed by Liston and others.

Among the members of the staff who were present were:—Drs. Hale White and Shaw, Messrs. Charters J. Symonds, C. H. Fagge, Eason, Mollison, Bellingham Smith, Hopson, Dowsett and Aubrey. Most of the junior staff were also present, and a fair number of past and present Guy's men.

The exhibits were divided into a scientific and a commercial section. In the Histological Laboratory was an excellent exhibit from the Bacteriological Department, arranged by Dr. Eyre and Mr. Catto. It included a number of very fine slides, and a series of exhibits showing the various stages, complete in every detail, of the Wassermann reaction. Dr. Eyre, undaunted by the strains of the "Dollar Princess," &c., which proceeded from the band at the head of the staircase outside, gave a clear account of the meaning of the test and the method of carrying it out, to an interested crowd. There was also a demonstration of the preparation of a vaccine from beginning to end. Dr. Boycott and Dr. Goodhart showed a set of slides on the pathology of the liver, including an interesting series on chloroform necrosis. Dr. Price Jones showed Bürken's modification of the Thoma-Zeiss Hæmocytometer, and Mr. Mollison a set of instruments for exact aural diagnosis.

In the new Physiological Research Room, Dr. Bellingham Smith and Dr. Chisolm exhibited mice with carcinoma and microscopical sections of mouse carcinoma; also an apparatus for measuring the quantity of radium by means of emanation in equilibrium with it. Dr. Ryffel demonstrated some chemical methods. In the Medical Radiography Room, Dr. Jordan demonstrated recent advances in radiography.

Among the commercial exhibits in the Museum was a splendid display of surgical instruments by Messrs. Down Bros. Mr. Grattan's stall contained a selection of the new medical and surgical text-books. Messrs. Ash had on show a model paper-making machine, which was actually making paper all the evening, and attracted a good deal of attention. They also had a display of paper-making by hand, and specimens of printing and bookbinding. Mr. Rogers exhibited some ingenious pharyngeal and nasal sprays.

In the Committee Room of the Medical School Office, Messrs. C. & A. Hœfftcke exhibited their well-known appliances for fracture, joint, and orthopædic cases. The Holborn Surgical Instrument Company were showing a selection of their instruments, and Messrs. Meyerowitz optical apparatus, cystoscopes, &c.

In the Histological Laboratory, Messrs. Stanley, R. & J. Beck, and Leitz & Co. were showing microscopes, and the last-named firm also exhibited a dark-ground condenser showing living bacteria unstained, and the ultra-microscopic apparatus. Messrs. Hearson, among other things, showed a very neat and ingenious little incubator, designed for carrying out the Wassermann reaction.

In the Museum, Dr. Cock kindly demonstrated the collection of old surgical instruments, &c., which he has presented to the hospital, and he told us the history of some of them. He also showed a series of documents relating to Thomas Laurence, M.D. Padua, F.R.C.P. Lond., a 17th century court physician, and the M.D. Oxon. diploma granted to a later Thomas Laurence, grandson of the preceding, who was a physician and friend to Dr. Johnson. Among the earlier documents was a contemporary copy of the report of the post-mortem examination of Queen Anne, which was signed by Laurence as chief physician. Dr. Cock has kindly sent us a transcript of this interesting paper, which is as follows:—

At the Council Chamber, St. James's, the 3d August, 1714.

Present:

Their Excellencys the Lords Justices in Councill.

The Physicians called in and Dr. Laurence delivered the following paper, containing an Acct. of what was observedat the opening of her late Majtys. Body.

Kensington Palace,
2 August, 1714.

Upon opening the Body of her late Majesty of Blessed Memory, We found a small Umbilical hernia Omentalis without any excoriation, a large Omentum well Coloured. No water in the Cavity of the Abdomen. The Stomach thin, and its inward coat

too smooth. The Liver not Schircous, but very tender and Flaccid, as were all the rest of the Viscera of the lower belly. The Gall, Bladder, Kidneys, and Urinary bladder without any stone. There was a very small Scorbutic Ulcer on the left lag. We can give no further account, being forbid making any other inspection than what was absolutely necessary for Embalming the Body.

Then follow the names of the physicians who signed the document, including Laurence, John Arbuthnot, and Hans Sloane.

The lighter side of the Conversazione was provided by an excellent string band, under the direction of Mr. Eugene Maney. Refreshments were provided in the Library, and the College Caterer deserves a word of praise for the way in which he carried out the arrangements for this important part of the function.

The organisation of the Conversazione was the work of the Society's energetic senior Secretary, Dr. Rippmann, who may be congratulated on the success of the evening, which was due so largely to his efforts. The various gentlemen who contributed specimens or other exhibits to the scientific part of the Conversazione also deserve our thanks.

Abstract of Introductory Dental Anatomy Lecture.

By Mr. W. A. MAGGS.

For many years past the Inaugural Address, delivered in the medical school at the beginning of each Winter Session, has been discontinued at Guy's, and in its place a paper has been given at the opening meeting of the Physical Society, and this year, as an innovation, a Conversazione will be held. It is not my intention to address you in lengthy and formal speech, but merely to say a few words of advice, and to extend to new students a welcome and such encouragement as I should like extended to myself were it possible for our relative positions to be exchanged.

In all ages and countries it has been the custom to give a hearty welcome to strangers, and, on behalf of my colleagues and myself, I assure you we are glad to make your acquaintance as new students, and hope you will reciprocate the good feeling that has always existed between the staff and students of Guy's. This cordial relationship is often commented upon by strangers, is not abused, and leads to the finest feelings of *esprit de corps*.

The opportunities of acquiring a practical and theoretical knowledge of dentistry are in your hands, and it rests with each of you to gain proficiency by steady and diligent work. Habits of application, perseverance and industry cannot be inculcated too early in life. Spasmodic work is invariably unsatisfactory, the plodder winning in the end, as in the fable of *The Hare and the Tortoise*.

It is truthfully said that there is plenty of room at the top of every profession, and this alone should be sufficient incentive for strenuous work. The tendency, no doubt, with most of us is to go in the line of least resistance, which in other words means that without some determination and character we do not struggle hard enough to attain our ideals.

It is not to be supposed that a moderate worker possessing merely ordinary ability can reach the highest position; therefore I want you, by earnest and constant endeavour, to learn all that is possible whilst your hands are young and brains active.

I have no sympathy with the student who desires to acquire just so much and no more of a subject as will serve him to pass an examination, and would remind him that as a professional man his education should be liberal and his culture wide.

Professor Jowett's maxim that every Balliol man ought to try to be "very" something should apply equally to Guy's men.

I have the greatest admiration for the practical Dentist, and the public is chiefly interested in his skill; at the same time I hope that many of you will continue your studies, and take medical qualifications.

The deeper knowledge of anatomy, surgery and pathology required by the medical man will not only expand the mind and make the specialism of dentistry more interesting, but, more important still, the knowledge gained will prove helpful in practice. The advisability of seeking a medical qualification is not unanimously agreed upon by dentists, some preferring to take a degree in dentistry.

I would recommend you the former course, because I consider the Licentiate in Dental Surgery of the Royal College of Surgeons of England a competent dental surgeon; but in either choice I would commend you, and venture to assert that the two or three years' extra study, and the necessary expense involved, will well repay you in later life.

It is my duty and pleasure to lecture upon dental anatomy, a subject with which you must become familiar ere you can successfully or scientifically practise dentistry. The form, structure, and development of the teeth, jaws, and gums

will be described, and the dentitions of vertebrate animals studied in so far as they tend to make you understand more clearly the human dentition.

The calcification and eruption of the teeth require more complete elucidation, and it is hoped that some of you may help in the investigation of these obscure physiological processes.

It is not intended that you should become Professors of Comparative Odontology, but the range of view should include other than human teeth, and as members of a liberal profession and specialists in dentistry, you should be acquainted with the evolution of the teeth and the various types of dentition, be they herbivorous, carnivorous, omnivorous, or other forms.

To my mind it would be as unnecessary and unprofitable to commit to memory dental formulæ, and minute differences of animal dentitions, as it would be to the geographer to learn the populations of the smaller towns.

It is impossible to learn dental anatomy from books alone—the derivation of the word anatomy indicates its purpose, ἀνά = up, τέμνω = to cut; therefore the microscope and the inspection of specimens will be brought to your aid.

The Museums of Guy's Hospital, the Royal College of Surgeons, and the Natural History Museum contain abundance of excellent specimens of the jaws and teeth of vertebrates, and you should visit these institutions.

The books recommended for reading are Owen's *Odontography*—the masterwork, and excellent for reference. Tomes' *Dental Anatomy;* Hopewell-Smith's *Histology of the Teeth and Jaws;* Underwood's *Comparative Odontology.*

At the conclusion of each lecture from ten to fifteen minutes will be devoted to the interrogation of the class—an easy way of bringing home to your minds how much has been learned at former lectures.

"Act well your part—there all the honour lies."

POPE.

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

A Correction.

SIR,—In the notice of the Ball, placed as an inset in your last issue, the Hon. Mrs. Beddard's name was incorrectly given in the list of Lady Patrons. I much regret this clerical error.—Yours truly,

J. G. SANER,
Hon. Sec. Rugby Club Ball.

Guy's Hospital,
October 11th, 1910.

A Note on Wassermann's Reaction.

BY W. H. CATTO, AND J. W. EYRE.
(From the Bacteriological Department, Guy's Hospital.)

IN the first instance, it is necessary to become quite familiar with some terms that are used in connection with this reaction. A substance of any kind (bacterium, red cell, piece of stomach, etc.), when injected into an animal (rabbit or man), provokes a response on the part of the animal, which results in the formation of an antibody in the serum, to which are given the various names of Immune Body, Amboceptor, or Lysin (*e.g.* Hæmolysin). This body is capable of entering into combination with material similar to that inoculated, *sensitizes* it (hence its French name substance *sensibilizatrice*) and by rendering it capable of being acted upon by the complement normally present in the serum indirectly causes its disintegration. The name antibody, as applied to this substance, is unsatisfactory, because it embraces also other bodies known as agglutinins, antitoxins, and opsonins, which have nothing to do with the matter under consideration, and it behoves us to adopt, once and for all, a term that will not lead us into any confusion. Of the various names before mentioned, "lysin," with its appropriate prefix (Hæmo- Bacterio-, etc.), seems the most suitable, as it implies the specific nature of the substance and the inimical properties it exercises towards the infecting material.

The agent which is responsible for this reaction on the part of the inoculated animal receives, quite properly, the name of Antigen—the antibody producer. There are different kinds of antigens. Infecting bacteria are antigens, so are red cells, spirochætes, etc.

The antigen, as has been pointed out already, can only be destroyed by a body normally present in any serum, after it has been sensitized by its specific lysin. This destroying body is known as Complement, because it *completes* the chemical combination in consequence of which the antigen is disintegrated.

To summarise, then :—

Antigen = Injected or infecting material.
— Lysin = Specific substance produced by the cells of the body as a response to the antigen; whose rôle consists in sensitizing the antigen and fixing the complement.

Complement = Substance normally present in the blood which is attached by the lysin to the antigen, and destroys it.

From a consideration of these facts, Bordet and Gengou elaborated a reaction, by means of which certain infective conditions could be diagnosed, the reaction depending on the presence or absence in the suspected serum of the corresponding *lysins*. Their investigations were carried out in connection with typhoid fever.

By bringing together the patient's serum (deprived of its complement in a manner to be described below), an emulsion of typhoid bacilli, and a known dose of complement obtained from a guinea-pig's serum, they were able to produce a fixation of the complement so that on the further addition of a solution of erythrocytes and of the similarly inactivated serum of a rabbit, immunised to red cells, no hæmolysis of the corpuscles took place, because the complement, having been firmly bound in the first instance, was no longer at liberty to act on the second group. A modification which was soon introduced was the substitution of a solution of bacterial extracts to the emulsion of bacteria first used.

Later on Neisser and others found that the serum of apes infected with syphilis contained specific lysins, which could bring about a similar fixation of complement, in the presence of an extract of a syphilitic organ. (It was found, however, that lipoid was capable of acting in the capacity of antigen, and that extracts of organs other than syphilitic ones, such as guinea-pig's heart or normal human liver, were for practical purposes as good antigens, but in our opinion more reliable results are obtained by using the original method, viz., syphilitic fœtal liver, for this contains, in addition, the products of the actual infecting organism upon tissue cells.)

This reaction was subsequently applied by Wassermann to the diagnosis of syphilis in the human subject, and as the results obtained are getting more and more reliable, the test is now receiving the greatest attention in connection with general clinical work.

The accompanying diagram may help to make clear the various combinations of the different groups. (Diagram A.)

The technique we employ in carrying out the reaction in the laboratory is as follows:—

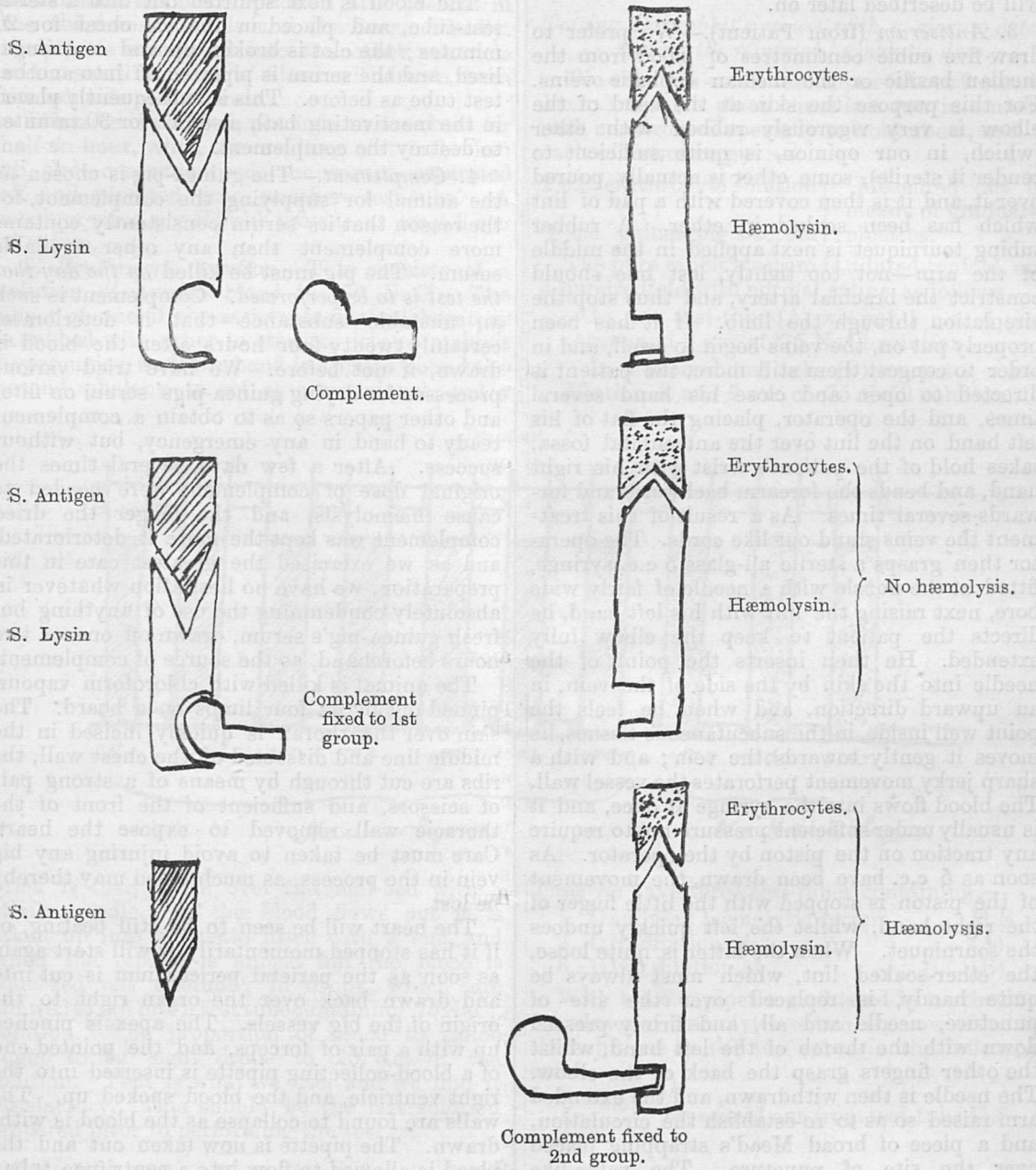
1. *Hæmolytic serum.*—The hæmolytic serum is obtained by inoculating a rabbit with 3 or 4 c.c. of washed human cells at intervals of eight or ten days for a month or six weeks; at the end of that time the rabbit's serum is found to have sufficient hæmolytic power to be of use in the test. The erythrocytes we use are human erythrocytes, which can be obtained from the wards, where there are constantly patients who either have to be venesected, or else whose blood requires to be investigated for micro-organisms. In the latter cases the cultures very often remain sterile, and there is no objection to those cells being made use of. If we cannot obtain any cells in this fashion, then one or other of us in the laboratory is always willing to provide them.

The blood is first drawn into 1 per cent. sodium citrate solution, to prevent the formation of fibrin; it is then centrifugalised, the cells sinking to the bottom of the test tube; the clear supernatant fluid is drawn off, and normal saline solution added in order to thoroughly wash the cells. This process is repeated several times, and finally the erythrocytes are poured out into a sterile capsule, sucked up into a sterile syringe, and injected into the peritoneal cavity of the rabbit. At the end of six weeks, when the rabbit has been inoculated about four or five times, and it is supposed that he has attained a high degree of hæmolytic power, his ear is thoroughly rubbed with xylol, after the preliminaries of shaving. The vein which runs along the posterior border is pricked with a surgical needle, and the blood, as it flows out, caught, preferably in a centrifuge tube. It is possible thus to draw off about 4 or 5 c.c. of blood. This is placed in the ice chest for half an hour, and allowed to clot. At the end of that time the clot is broken up, the tube placed in a rapidly revolving centrifuge (2000 per minute) for fifteen minutes, and the serum is then found to have separated off and to be lying, as a clear yellow fluid, on the top. It is slowly pipetted off into another test-tube, care being taken not to transfer any red cells with it.

The tube containing the pure serum thus obtained is placed in a water bath at 56° C. for half an hour, for the purpose of "inactivating" it, that is to say, destroying the complement it naturally contains. The measure of the hæmolytic power of the serum depends, as one would expect, on the response which the animal yields to the inoculation, so that in every individual case this serum has to be *tested* in order to ascertain the proper hæmolytic dose to use. A description of this process will be given further on.

2. *Antigen extract.*—If possible, one should obtain the liver from a syphilitic fœtus; our extract was prepared from the liver of a small

Diagram A.



child which died in hospital with the unmistakable signs of congenital syphilis about him. The liver is extracted with four times its weight of absolute alcohol. The liquid is strained off, then filtered through filter paper into a big bottle with a glass stopper, and placed in an ice chest. A precipitate forms which sediments, and care must be taken afterwards not to shake the bottle lest the precipitate should be disturbed. The strength of the antigen extract becomes constant after eight or ten days, and it should therefore not be used before that. This

antigen requires standardising, as it varies with the particular organ extracted. The process will be described later on.

3. *Antiserum* (from Patient).—We prefer to draw five cubic centimetres of blood from the median basilic or the median cephalic veins. For this purpose the skin at the bend of the elbow is very vigorously rubbed with ether (which, in our opinion, is quite sufficient to render it sterile), some ether is actually poured over it, and it is then covered with a pad of lint which has been soaked in ether. A rubber tubing tourniquet is next applied in the middle of the arm—not too tightly, lest one should constrict the brachial artery, and thus stop the circulation through the limb. If it has been properly put on, the veins begin to swell, and in order to congest them still more, the patient is directed to open and close his hand several times, and the operator, placing the flat of his left hand on the lint over the antecubital fossa, takes hold of the patient's wrist with his right hand, and bends the forearm backwards and forwards several times. As a result of this treatment the veins stand out like cords. The operator then grasps a sterile all-glass 5 c.c. syringe, fitted at the nozzle with a needle of fairly wide bore, next raising the lint with his left hand, he directs the patient to keep the elbow fully extended. He then inserts the point of the needle into the skin by the side of the vein, in an upward direction, and when he feels the point well inside, in the subcutaneous tissues, he moves it gently towards the vein; and with a sharp jerky movement perforates the vessel wall. The blood flows into the syringe at once, and it is usually under sufficient pressure not to require any traction on the piston by the operator. As soon as 5 c.c. have been drawn, the movement of the piston is stopped with the little finger of the right hand, whilst the left quickly undoes the tourniquet. When the latter is quite loose, the ether-soaked lint, which must always be quite handy, is replaced over the site of puncture, needle and all, and firmly pressed down with the thumb of the left hand, whilst the other fingers grasp the back of the elbow. The needle is then withdrawn, and the extended arm raised so as to re-establish the circulation, and a piece of broad Mead's strapping placed over the site of puncture. The valve-like opening made into the vein prevents the extravasation of blood into the subcutaneous tissues. There should be no spilling of blood anywhere, and the whole process should, if everything is ready at first, only occupy two or three minutes. The chances of air getting into the vein are remote, and the patient feels no discomfort whatever beyond the prick.

The blood is next squirted out into a sterile test-tube, and placed in the ice chest for 20 minutes; the clot is broken up and centrifugalised, and the serum is pipetted off into another test tube as before. This is subsequently placed in the inactivating bath at 56°C. for 30 minutes to destroy the complement.

4. *Complement.*—The guinea-pig is chosen as the animal for supplying the complement, for the reason that its serum consistently contains more complement than any other available serum. The pig must be killed *on the day that the test is to be performed.* Complement is such an unstable substance that it deteriorates certainly twenty-four hours after the blood is drawn, if not before. We have tried various processes for drying guinea-pigs' serum on filter and other papers so as to obtain a complement ready to hand in any emergency, but without success. After a few days, several times the original dose of complement were needed to cause hæmolysis, and the longer the dried complement was kept the more it deteriorated, and as we exercised the greatest care in this preparation, we have no hesitation whatever in absolutely condemning the use of anything but fresh guinea-pig's serum, drawn off one or two hours beforehand, as the source of complement.

The animal is killed with chloroform vapour, pinned out by its four limbs on a board. The skin over the thorax is quickly incised in the middle line and dissected off the chest wall, the ribs are cut through by means of a strong pair of scissors, and sufficient of the front of the thoracic wall removed to expose the heart. Care must be taken to avoid injuring any big vein in the process, as much blood may thereby be lost.

The heart will be seen to be still beating, or if it has stopped momentarily, it will start again as soon as the parietal pericardium is cut into and drawn back over the organ right to the origin of the big vessels. The apex is pinched up with a pair of forceps, and the pointed end of a blood-collecting pipette is inserted into the right ventricle, and the blood sucked up. The walls are found to collapse as the blood is withdrawn. The pipette is now taken out and the blood is allowed to flow into a centrifuge tube; at the same time the hold on the apex is relaxed somewhat to allow the heart to beat. In consequence of this, more blood flows from the right auricle into the right ventricle, and this in turn is drawn off by means of the pipette. The process is repeated as often as possible, and

when no more blood can be sucked out, the abdomen of the guinea-pig is pressed firmly so as to obtain the blood which is still present in the abdominal vessels and the liver. Finally, the pipette is inserted into the other ventricle and a small amount of blood withdrawn from the left side of the heart.

The tube is plugged, put into an ice-chest for half an hour, when the resulting clot is broken up and centrifugalised, the serum separated off and pipetted into another test-tube. A medium-sized pig should provide at least 3 c.c. of serum.

5. *Erythrocyte solution.*—This consists of a solution of human blood in ·75 NaCl. The finger of one of the assistants in the laboratory is rubbed with ether to sterilize it and make it hyperæmic; a rubber band is applied round the second phalanx to act as a tourniquet, and a prick is then made over the nail-bed with a sterile needle. As the blood flows out it is taken up into a pipette fitted with a teat, and when the pipette is almost full the blood is squeezed out gradually in drops, which are allowed to fall into a test tube containing ·75 NaCl. solution. The proportion of blood to saline ought to be eight drops to 20 c.c. of the solution. That is what we use, and we find it satisfactory. This should be the last solution prepared prior to performing the test.

By a long series of experiments, the unit of antiserum required has been ascertained, and it has been found convenient to use ·2 c.c. of the decomplementised material. Similarly, the dose of guinea-pig's serum has been determined as ·1 c.c., whilst the unit of erythrocyte solution is 1 c.c. The hæmolytic serum and the antigen extract, on the other hand, are never constant, therefore they always require testing before use.

Testing the rabbit's serum with a view to determining the minimal hæmolytic dose.

We take ten small test-tubes (about 9 c.m. by 1 c.m.), and we place them in a row in a nickel rack constructed specially to hold them, and in each of them we put:—

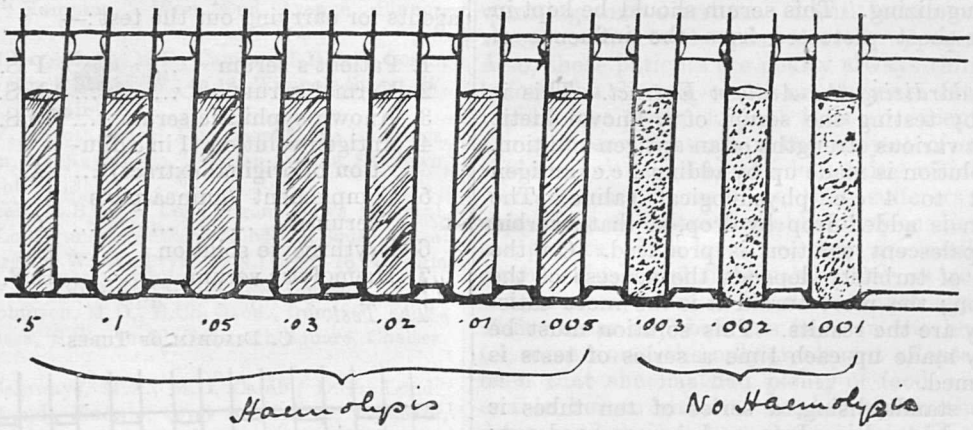
1 c.c. erythrocyte solution
·1 c.c. guinea-pig's serum
} Measured out by means of graduated pipettes.

The pure rabbit's serum is diluted tenfold, and a hundredfold with normal saline, as follows:–

In one test-tube (A) we put 1 c.c. of pure serum and 9 c.c. of ·75 NaCl solution.

In a second test-tube (B) we put 1 c.c. of dilution A and 9 c.c. of ·75 NaCl solution.

Diagram B.



Thus we have three test-tubes containing:—

1. Undiluted hæmolytic serum ... H.S
2. 1/10 dilution of ... ... (A)
3. 1/100 dilution of ... ... (B)

With a 1 c.c. pipette graduated in tenths of a c.c., doses of hæmolytic serum are now added to the solutions in the test-tubes in the following order:—

·5 c.c.
·1
} Measured out from test-tube H.S.

·05
·03
·02
·01
} Measured out from test-tube (A).

·005
·003
·002
·001
} Measured out from test-tube (B).

The volume of fluid in each little tube is brought to the same level by the addition, where necessary, of normal saline solution. Each tube is then well shaken to ensure thorough mixing of the contents, plugged, labelled and incubated at 37°C. for an hour. In the case of the hæmolytic serum we are now using it was found that hæmolysis took place in the first seven tubes and not in the three last. Vide the accompanying diagram. (Diagram B.)

Therefore ·005 c.c. represents the minimal hæmolytic dose of our serum; and as the various substances used in the reaction tend to neutralize the effect of the hæmolytic serum, four times the smallest hæmolytic dose is taken as the unit of hæmolytic serum when performing the test. Seeing that ·02 c.c. of serum is quite a suitable dose to work with, the rabbit is instantly killed, and as much blood as possible removed from the heart; its serum is then pipetted off and inactivated after clotting and centrifugalizing. This serum should be kept in the ice-chest protected from the influence of light.

Standardizing the Antigen Extract.—This is done by testing the serum of a known luetic against various strengths of an antigen solution. The solution is made up by adding 1 c.c. antigen extract to 4 c.c. physiological saline. The antigen is added drop by drop, so that a turbid and opalescent solution is produced. On the degree of turbidity depends the success of the reaction; the more turbid it is the more satisfactory are the results. This solution must be freshly made up each time a series of tests is performed.

For standardising, a series of ten tubes is arranged in order. Into each is measured out:

1. One unit antiserum (Luetic).
2. One unit complement.
3. One unit erythrocyte solution.
4. Various strengths of antigen solution, viz., 1, ·9, ·8, ·7, ·6, ·5, ·4, ·3, ·2, ·1 c.c. respectively.

The tubes are well shaken up, plugged, labelled and incubated at 37° C. for an hour. At the end of that time they are taken out and a unit of hæmolytic serum added; they are then replaced in the incubator for two hours and allowed to stand overnight. If none show any hæmolysis the experiment has to be repeated, using only tenths of the quantities already used. But supposing that those containing ·1 and ·2 c.c. respectively show hæmolysis, whereas none of the others do so, then we know that the dose of antigen necessary to fix the complement in the presence of 1 unit of syphilitic serum lies between ·3 and ·2 c.c. of our solution. So we now arrange another series of eleven tubes containing the same reagents as before, but with different doses of antigen solution, viz., ·3, ·29, ·28, ·27, ·26, ·25, ·24, ·23, ·22, ·21, ·2 c.c. respectively.

Supposing we find that in the tubes labelled ·3—·25 no hæmolysis occurs, but that ·24—·2 show hæmolysis, then we conclude that the smallest dose for fixing the complement is ·25 c.c.

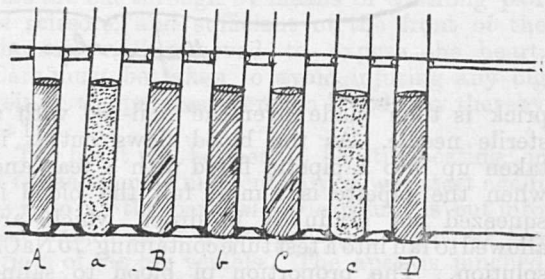
We next institute another series of experiments to find out what is the maximum dose between ·3 and ·25 c.c. that will prevent hæmolysis with a syphilitic serum and still allow hæmolysis with a normal serum, because antigen, by itself, independent of syphilitic lysins, has the power, in comparatively large doses, of deviating the complement. In this fashion we determine as accurately as possible the dose of antigen we want for the reaction.

We are now in presence of the necessary agents for carrying out the test:—

		Unit.
1. Patient's serum	P.S.	·2 c.c.
2. Normal serum	N.S.	·2 c.c.
3. Known syphilitic serum ...	S.S.	·2 c.c.
4. Antigen solution (1 in 5 dilution of original extract) ...	A.	·25 c.c.
5. Complement (guinea-pig's serum)	C.	·1 c.c.
6. Erythrocyte solution ...	E.	1 c.c.
7. Hæmolytic serum	H.S.	·02 c.c.

The Test.

C. Diagram of Tubes.



Added after 1 hrs. incubation at 37° C.

A. contains E+C+P.S. ... +H.S. ... hæmolysis.
a. contains E+C+P.S.+A ... +H.S. ... no hæmolysis.
B. contains E+C+N.S. ... +H.S. ... hæmolysis.
b. contains E+C+N.S.+A ... +H.S. ... hæmolysis.
C. contains E+C+S.S. ... +H.S. ... hæmolysis.
c. contains E+C+S.S.+A ... +H.S. ... no hæmolysis.
D. contains E+C +A ... +H.S. ... hæmolysis.

The normal serum serves as a negative and the known luetic as a positive control. Tube D is brought in to the series to show that the

antigen by itself is not strong enough to deviate the complement. **A**, **B**, **C**, are controls without antigen.

In the case represented diagrammatically the reaction is positive and the diagnosis of syphilis is established.

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(The Editor will be very glad to receive a postcard with notes of any change of address.)

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The Treatment of Exophthalmic Goitre.

CLINICAL LECTURE BY W. HALE WHITE.

GENTLEMEN,—As some of you know, there are in Mary ward at the present time two women suffering from exophthalmic goitre. The first is in number 7 bed, is 25 years old, and the points of interest in her case that I want to mention to you are, that she has the ordinary classical symptoms of the disease: prominence of the eyes, enlargement of the thyroid, and rapidity of the pulse. In addition, it is worthy of note that she was frequently sick before she came in, and lost considerable weight; she has also got weaker and has suffered from a nervous breakdown. That serves to remind you that people with exophthalmic goitre are very liable to vomiting and diarrhœa. I will return to that when coming to the post-mortem appearances. Also, these patients are nearly always thin. If, before the disease comes on, they are fat they rapidly lose flesh, so that it is an exceptional thing to see a fat woman the subject of exophthalmic goitre. And the last thing which this woman reminds us of is, that sufferers from exophthalmic goitre are liable to various neurotic complaints. For instance, they are easily excitable, blush and flush easily, and, as we shall see later on, some of them drift into asylums. This woman in 7 bed has been in the hospital for some time; the only treatment adopted has been that she has had plenty of food, so as to enable her to gain in weight, which she has done; and she has been kept absolutely at rest in bed. She came in on 22nd July, and there is a note on the 16th of August saying she is bright and cheerful, and that on fine days the bed is removed to the veranda and she enjoys the fresh air. So in the treatment of that woman you have a reminder of what is the best treatment for exophthalmic goitre, namely, complete and absolute rest, plenty of food and plenty of fresh air. A note on the 7th of September says that the general health of the patient is much improved, and that she has gained four pounds four ounces in weight. The next note about her is on the 19th of September, which states that her wrist was definitely painful, and that she has been put upon salicylates. Her heart was listened to, but no organic murmur could be heard. I would remind you that people with exophthalmic goitre are more liable than others to suffer from rheumatic fever

What the association means I do not know, but it is a well-established fact.

The next case, three beds further down, is that of a woman aged 21. Note that both the patients are women; the disease is much commoner in women than in men; it occurs mostly between the ages of 20 and 30. Both our patients are between those ages. This patient had the ordinary classical symptoms which we mentioned before. The patient's mother is now alive, having recovered from a condition said to have been similar to this patient's which she suffered from twenty years ago. I have on two or three occasions come across exophthalmic goitre in families. It is interesting to see that the patient's mother recovered, because that illustrates the tendency of exophthalmic goitre in many people to recover if left to itself, because patients in the station of life occupied by hospital patients are not usually able to adopt any prolonged or expensive treatment, and at the date at which this patient's mother had the disease, certainly no operation would have been done for it. This patient says her trouble began three years ago with enlargement of the thyroid. She says she is sick from time to time, which illustrates gastro-intestinal effects. She has lost two stone in weight, thus again illustrating that these patients get thinner. There is little else to call your attention to about the case except this very important thing, that after she had been in for some time she developed well-marked chorea. You might, perhaps, think we were wrong and mistook the tremors of exophthalmic goitre for chorea. But the movements are so distinct that I am certain we have not made that mistake. The tremor of exophthalmic goitre is very small and fine and regular, whereas the tremor of chorea is large and irregular. Everyone here knows that rheumatic fever and chorea are associated, and so the fact that our second patient has developed chorea is very interesting as showing the association between the rheumatic fever group of diseases and exophthalmic goitre. That was illustrated by our first patient.

I thought these two cases would form a good basis for a discussion this afternoon about some points in connection with this disease, and, thanks to Dr. Jan Mahomed, who was my clinical assistant, I have before me the reports of many cases of chorea. He investigated the cases which had been in the hospital from the years 1888 to 1907, and found there had been admitted into Guy's 169 cases of chorea; 21 of these died in the hospital, 54 of the total we were able to trace, and the remaining 94 could not be found, although each of them was written to three times. So we have a very fair number of cases on which to speak this afternoon. I think the first point to mention will be concerning the cases which died in the hospital. Let us see if we can learn anything from the deaths from exophthalmic goitre, because, after all, we do learn most about a disease by seeing after death what effects are produced on the body by it. Twenty-one of the 169 died in hospital, and we have here what was found. I have already mentioned that vomiting and diarrhœa are frequent symptoms in some cases of exophthalmic goitre. Of these 21 who died in hospital, 11 had bad vomiting and diarrhœa, so that as regards the hospital patients, at any rate, you see that vomiting and diarrhœa are a serious matter. That being so, we can state the clinical lesson that if you are confronted with a patient who has vomiting and diarrhœa in association with exophthalmic goitre it behoves you to put her to bed at once and try to stop the vomiting and diarrhœa. You will not find vomiting and diarrhœa among patients with exophthalmic goitre outside the hospital so frequently as among patients inside, and I think the reason is simply that in the better classes of society the women can afford to lie up and go to bed from the first onset of diarrhœa or vomiting, whereas the poorer women work on, and so the trouble gets the upper hand. At any rate, inasmuch as 11 of our 18 fatal cases had it severely, we must be careful to put the patient to bed, give appropriate drugs, and put her on suitable food, such as peptonised milk, or whatever we may decide, so as to stop it. Post-mortem you find some indication of it, for very often in the post-mortem room, if the patients have had considerable vomiting and diarrhœa, you are struck with the great prominence of Peyer's patches, suggesting that the lymphatic structures of the intestine are in a very active condition; and it would be very valuable if, bacteriologically, we could find, as I hope we shall some day find, the micro-organism which is responsible for the gastro-enteritis of exophthalmic goitre, because it is conceivable we may then do the patients some good with a vaccine. Reference to the enlargement of Peyer's patches brings me to another point which is of interest in exophthalmic goitre, and that is that certain structures of the body are very liable to be found enlarged, because not only are Peyer's patches enlarged, but in a large proportion of the fatal cases of exophthalmic goitre the thymus is extremely large, and, to a less extent, the tonsils and lymphatic glands of the body. In other words,

people with exophthalmic goitre are very liable to have, as a complication of it, the condition known as the "status lymphaticus," which is such a terror to the anæsthetists, because it is very difficult to foretell, and is a cause of sudden death under an anæsthetic. Nearly all the patients who have died as a result of operative interference for exophthalmic goitre have been found to have the status lymphaticus, enlarged thymus, and enlargement of the lymphatic structures throughout the body generally, and several have died while under the anæsthetic. I, however, know of at least one patient who died immediately after operation for exophthalmic goitre, and no enlargement of the thymus was found after death. Patients with exophthalmic goitre take an anæsthetic so badly that it has been recently suggested that they should be trained for several days or weeks beforehand, with an imaginary taking of an anæsthetic, with the face piece, and so on, so that when the actual anæsthetic is administered they will not take fright. But the fact that we so frequently find status lymphaticus in fatal cases of exophthalmic goitre, goes to partly explain why several cases, when operated upon, have died under the anæsthetic.

The next thing which strikes one on looking down the records of these 18 cases is, that 6 of the fatal cases were delirious, 1 was comatose, 2 were melancholic, and 1 had mania. That is a very large proportion of cases with nervous symptoms, but I may add that in none of them was anything found at the post-mortem to account for these symptoms. It is notorious that exophthalmic goitre is associated with an instability of the nervous system, for it is a suggestive connection that the symptoms of exophthalmic goitre are just the symptoms of severe fright. When a person is severely frightened the eyes are prominent, the pulse rapid, and she trembles, and the neck is even said to swell sometimes. Then also exophthalmic goitre has been known to be suddenly induced by a severe fright. Further, you will find, many years ago, in the Guy's Reports, a paper by Dr. Savage on exophthalmic goitre in relation to insanity, and it shows there is a larger proportion of sufferers from exophthalmic goitre among the insane than one would have expected. I remember a woman in the hospital with this disease who had to be taken away because she tried to commit suicide. So there is a close association between nervous ailments and exophthalmic goitre. Of the 18 fatal cases 1 was found to have mitral disease, 1 had severe endocarditis and pericarditis, and 2 had rheumatic fever. I have already mentioned the fact that patients with exophthalmic goitre are more liable to have had rheumatic fever than are ordinary people, and these figures illustrate it, because out of 18, 4 had direct evidence of recent or past rheumatic affection of the heart. One died of diabetes. There is an association between exophthalmic goitre and sugar in the urine. I do not know the precise number, but a moderate number of people with exophthalmic goitre have sugar in the urine, and I have known two deaths outside the hospital from diabetic coma in patients who have had exophthalmic goitre. Do not be altogether too gloomy after what I have told you if you find sugar in the urine, for I have been able to follow the case of a sister of a man who was a student here who I know had sugar in her urine in association with exophthalmic goitre eighteen years ago. The sugar persisted two years, then the exophthalmic goitre slowly subsided, and she has been for the last sixteen years perfectly well, works hard, and engages in a good deal of philanthropic work, and her brother tells me that the sugar has not returned. So it is possible to get rid of the glycosuria which is known to accompany exophthalmic goitre.

Of the hospital patients that we were able to trace, some had been operated upon, and therefore they will be useless for the study of the natural history of the disease; but if we deduct those that died in the hospital and those who were operated upon in the hospital, we have 40 left. And from those 40 I propose to derive some points about the natural history of the disease. I group them, first, into cases which have done well, and there are 26 in that group. Secondly, those who have done moderately well, or simply described themselves as better, 12. Those who have not done well are 2. I may mention that these patients have all been written to within this year, so that when a patient was in the hospital many years ago we know the result for a long period after the patient has left us. Of those who have done well some have done very well. For instance, one writes to say that she has required no treatment since she left the hospital twenty-one years ago. Another was very bad in the hospital twenty years ago, and she has worked hard for eighteen years, and is married, has had three children, and is now a widow. A woman was in the hospital twenty years ago, has since been working as a district nurse, subsequently married, is alive and well, and has four children. Number 9 was in the hospital sixteen years ago, has not had a doctor for twelve years, and is perfectly well. Number 15 was in the hospital

eleven years ago, having had the disease ten years. She has had no treatment since leaving the hospital, is married, and has six children. Number 18 is well, has been in service five years, without a single day's illness. And so I might go on reading to you how well these 26 patients have been. One will amuse you, number 40, who was in the hospital over eight years ago. She has been well ever since she left the hospital; went into service for four years, then married and has four children, and writes to say she never needs a doctor, although she pays into a club, which I think you may take to be proof positive that she is very well.

With regard to those who have done moderately well, a good many of them have done very well as regards their exophthalmic goitre, but I put them into the group of "moderately well" because they so describe themselves in their letters. Here is one who says her health is fairly good, but she was able to take a situation after leaving Guy's; she then married, and has two children. Even the two that did not do well say they are somewhat better. So we may conclude from these 40 cases that there is a strong tendency on the part of the disease to get well. And one interesting thing came out when I analysed these cases from another point of view, paying particular attention to the patients whose report was headed that they left the hospital *in statu quo*, or not improved. I followed them up, and a very large proportion of them got well. It appears that the disease has a tendency to get well in many patients, and often when they did not stay in the hospital long enough for this tendency towards getting well to show itself before they left it manifested itself afterwards, and they ultimately got quite well. I followed up cases which I have seen outside the hospital, and there one learnt an interesting thing. A large number of them, as among hospital cases, got well, but I also learnt that a larger proportion of them outside the hospital got well than among hospital patients. I think the explanation of it is that patients in such a social position that they do not attend a hospital can afford to rest. Everyone who has gone into the subject admits this fact, that sufferers from exophthalmic goitre drawn from the upper and middle classes do better than those socially below them. I remember well one patient seen outside the hospital who had great œdema of the legs and bad exophthalmic goitre with a failing heart. She is perfectly well. There was a man whose thyroid became large, and when I saw him he had only had the disease fourteen days, apparently following influenza. His pulse was almost uncountable, he had not slept for nights, he was delirious, and everyone thought he was dying; his eyes were protruding in an extraordinary way. Fortunately that night we got him to sleep with hyoscine. His sleep seemed to benefit him, and in a year he was perfectly well. Then there is a case which is interesting historically. I remember an old lady who had pneumonia, and she told me she had been a patient of Sir Samuel Wilks many years before that suffering from exophthalmic goitre. There was no trace of it left, and she had perfectly recovered from it. I will only mention one last case. I call to mind seeing a woman with very bad exophthalmic goitre with a pulse of 150, prominent eyes, big swollen neck, but on looking at the neck I saw a scar on one side, and I then learned that a few years ago she had had the left lobe of the thyroid removed on account of exophthalmic goitre. She had been better after that, but now was as bad as ever. Her sister, who had had the disease, too, had refused to be operated upon, and she was well. On the other hand, the patient who had one lobe removed had developed an enlargement of the other, and was now suffering from an extreme degree of exophthalmic goitre. She was made to rest for many months, and she is now perfectly well and working. As illustrating that patients do better outside the hospital than in, I have grouped them into cases which are mild, severe, and very severe. And it works out that the advantage that people outside hospital have is that the severe cases are more likely to do well than they are among hospital patients. One other thing is that the patients outside the hospital who do not do well generally have something else the matter with them; one has arterial sclerosis, another has Raynaud's disease, and so on. I also took the cases from another point of view. I asked a friend of mine, who is an actuary, to deal with them actuarially. According to the "Healthy Females' Experience of Twenty British Offices amongst Assured Lives," the total number of deaths that might have been expected to occur among the patients if they had been healthy was eight, whereas fifteen of them were dead from some cause or other. So, although, as I have pointed out in the wards, exophthalmic goitre rarely kills, the expectancy of life from sufferers from it is not as good as among other people. But you must be cautious in applying this result generally to exophthalmic goitre, because my cases were all ill enough to come into the hospital or to desire a second opinion. But, on the other hand, no account is taken of those who were so ill that they died in the

hospital. But, taking them for what they are worth, these figures show that the expectancy of life among patients who have exophthalmic goitre is not as good as among other people. But do not be alarmed by finding that whereas it is eight among healthy women, it is fifteen among those with the disease, because the age incidence is twenty to forty, and the deaths among women of that period are very few.

A question which someone often asks when we are going round the wards, is whether or not we should operate for exophthalmic goitre. Let us consider what has happened here at Guy's in connection with these operations. Five cases have been operated upon and have not died; three cases have been operated upon and have died as an immediate result of the operation. That is a very heavy mortality. And when you are thinking of the mortality of operating for exophthalmic goitre, I want you to remember this about it; that you operate upon a woman who has no immediate prospect of dying, and in twenty-four hours she is dead. It is a different thing from operating for acute general peritonitis, even if the patient does die after the operation, because with that disease the patient would be dead in a few hours if you did not operate. But in patients with exophthalmic goitre there is no great tendency on the part of the disease to kill. So you must think seriously before operating for exophthalmic goitre, when, out of eight operations done here, there have been three deaths. Following up the five that did not die: the first says she is better; the second says she is fairly well; the third says she received great benefit, but her health is now very bad at times. The next says she is perfectly well, the next says she is by no means well. In all these cases three or more years had elapsed since the operation, and all were mild or average cases. None of the three cases who died in hospitals was severe. One of them died the day after operation from nervous symptoms and pyrexia, one also died the day after operation, and one died on the operation table while the inferior thyroid arteries were being tied. Of cases outside that I have come across which have been operated upon, there are three. One I have mentioned; it was the patient whose other lobe enlarged afterwards, and she became as bad as ever, so that operation was not very successful. Another was better after removal of one lobe of the thyroid, and sixteen years after the operation she is distinctly better, there is no prominence of the eyes, but the pulse is sometimes rapid, and sometimes there is palpitation, but her doctor says the nervous symptoms are much the same, and she is still odd mentally. The third case outside the hospital died on the operating table after taking the anæsthetic. So I have got together eleven cases operated on; four of them died as the immediate result of the operation, so that is not a very encouraging state of affairs, and several of those who did not die are not cured. The result is much the same at St. Thomas's. Dr. Hector Mackenzie says that at St. Thomas's thirteen have been operated upon. Five were improved, three were not benefited, five terminated fatally as a result of operation. Of the cases which improved, two had no exophthalmos throughout; in the other three the exophthalmos did not appreciably diminish after operation, although the pulse became quieter. One case which was unimproved was operated upon sixteen years ago. Dr. Hector Mackenzie saw her recently, and her eyes were as prominent as ever, the tachycardia still remained, but there was no evidence of thyroid enlargement, and she came to see him because she had developed diabetes. Professor Kocher and Professor Mayo, in America, have published much better results, but they are very urgent on the point that you must only operate on the mild cases. But they are just the cases which would get well by rest in bed without operation. And these results have been obtained by surgeons who have paid special attention to the subject, and such results are quite the exception. For instance, in this same number of the *British Medical Journal* a distinguished surgeon says he has had three fatal cases from tying the thyroid arteries. Remember, the actual deaths from severe and mild cases among those not operated were only fifteen as against eight for healthy people, and as surgeons agree that you should only operate upon mild cases, it hardly seems likely that operation will do very much for exophthalmic goitre. The only thing which may possibly be said in its favour is, that if the patient does well the recovery may perhaps be hastened, which would be important for wage-earners. But a woman would scarcely be regarded as unreasonable if she declined the operation. Our results at Guy's and St. Thomas's are that she would stand a considerable chance, by accepting operation, of being dead in a few hours.

What treatment will you adopt if you do not operate? You remember what I told you about the natural tendency often shown by the disease to get well if left to itself. By far the most important treatment is rest in bed, for months if necessary. In many cases it is not necessary for so long, but if it is a severe case the

patient may have to spend three months in bed, and must be given plenty of good food, so as to recover the loss of weight. They do better with fresh air, and therefore the bed should be by the open window or some such place. I am not sure that, unless given to treat particular symptoms, drugs do much good. I have often given Moebius' anti-thyroid serum, which is a serum from thyroidectomised goats. Some people think they are better for it, and sometimes I have thought they are better for it. I have never seen any harm from it, so we may try it. The only objection to it is that it is expensive, because if it is to give relief we must rapidly increase the dose. We should begin with 5m. thrice daily, and gradually get up to 30 or 40m., three times a day. It may be given in milk. Rodagen, a white powder of the dried milk of goats whose thyroid has been removed, is often used. Milk sugar is added as a preservative. Thirty grams three times a day is a usual dose. If the patients are very restless, certainly they require drugs to quieten them. Giving bromides or hyoscine may save the patient's life. If the pulse is very rapid, and the heart palpitates very much, you may do good by giving digitalis. A drug which is much given for the disease is belladonna. It is difficult to see how it does good, because it tends to make the patients delirious, and also tends to make the pulse rapid. But in considering treatment remember exophthalmic goitre is a disease which, in a considerable number of cases, tends to get well, and that the main part of the treatment is rest in bed, good food, and fresh air. Sometimes, after the patient has been resting in one place, she ceases to improve; continuing the rest in a fresh place not uncommonly restarts the improvement, and is of great benefit. During the treatment by rest the patient should be shielded from all worry.

Notes from the Throat Department.

Three Cases of Haematoma Septi.

Case 1.—Hettie R., æt. 17, attended Out-patients on August 17th, suffering from inability to smell or breathe through the nose. On August 14th patient got wet. The following day she complained of severe frontal pain, followed by a change in her voice and inability to breathe through her nose. On examination, a condition of Pharyngitis sicca was found, and there was a soft bilateral swelling of the nasal septum completely occluding both anterior nares.

The swelling was painted with 3 per. cent cocaine, on the left side, and opened. A small quantity of thin pus was squeezed out. She was instructed to use a warm nasal douche. On the 26th the incision was reopened. Smell had returned to a large extent. On September 2nd the swelling was much reduced in size, and smell was now quite normal, but she still complained of headache. Subsequently the swelling quite disappeared and headache diminished.

Case 2.—James G., æt. 3, attended Out-patients on September 2nd, the mother having seen a swelling in either nostril. There was a history of an injury to the nose seven days previously. The septum was swollen and completely filled up either nostril, and appeared as a red fleshy-looking swelling just within the nostrils. Hæmatoma of the septum was diagnosed.

On September 3rd the swelling had increased in size, and the nose was discoloured and swollen. An incision was made into either side of the septum, and about two drachms of pus escaped. The next day, owing to inefficient drainage, the pus had reaccumulated; another three drachms of exceedingly foul pus were evacuated. On September 6th fluctuation was obtained over the bridge of the nose, the septum was still swollen, and the swelling extended to the upper lip and margins of the mouth.

The patient was admitted into Lydia Ward. He was given an anæsthetic, and an incision was made in the middle line over the nose. There was an abundant flow of pus; no fracture was observed. Efficient drainage was secured, and when the patient was discharged, on September 14th, the wound had healed and the septum had returned to its normal size.

Case 3.—Henry S., æt. 3, attended Out-patients on September 16th, with similar symptoms to those in Case 2. There was a history that three weeks previously he had fallen on his nose. On examination the septum was found to be swollen, and bulging into both nostrils; there was a purulent discharge from the left nostril. He was given an anæsthetic, a small incision was made into the anterior part of each side of the septum, and a quantity of pus evacuated; a small gauze drain was put in each side. The drains were changed daily for four days, and omitted on September 21st. On the 23rd there was no pus present in the nose, and the septum had returned to its normal size.

Remarks.—Hæmatoma of the nasal septum appears to be a rare disease; according to Chiari only two or three cases are seen among some 10,000 out-patients attending his Klinik in Vienna each year; in English text-books the condition is spoken of as occasionally following injuries to the nose. In view of these figures it is interesting to record the above three cases, seen within the short period of two months at Guy's.

The rarity of the condition has some interest, too, when the prominence of the nose is borne in mind, and its consequent liability to damage. As might be imagined, it is most frequently seen in children after falls, and is usually due to injury to the cartilage of the septum.

When found in adults, the causes, apart from injury, are syphilis, small-pox, typhoid, or erysipelas.

The second and third cases above give a typical picture, a fall on the nose causing slight epistaxis, and a few days later a red polypoid-looking mass appearing in either nostril, blocking the air passage. These swellings are found to come from the septum, and fluctuation is to be felt. Almost invariably suppuration follows, though absorption of the effused blood has been seen.

The treatment is incision as soon as pus is diagnosed, and drainage with gauze.

Prognosis as to the subsequent shape of the nose must be guarded, as in some cases there may be considerable sinking-in of the bridge. W. E. F.

Reviews, etc.

Books for review should be addressed to The Editor, Gazette Office, Guy's Hospital, S.E. Their price should in every case be stated.

The Problem of the Crippled School Child. By E. D. Telford, F.R.C.S., Surgeon to the Manchester Hospital for Sick Children; Assistant Surgeon to the Manchester Royal Infirmary; and Visiting Surgeon to the Manchester Residential School for Crippled Children. (Sherratt & Hughes.) Price 6d.

Of all defective children, cripples are the most promising material for education, for they are often normal in mental powers, and, except for deformity, healthy in body. In order that they may be able to earn a living at some occupation suited to their infirmity, a proper education is even more important to these children than to others. Yet, under existing conditions, they are often allowed to remain illiterate, so swelling the ranks of the unemployed and criminal classes, and eventually drifting into workhouse infirmaries.

This pamphlet describes how the problem of the crippled school-child has been solved in Manchester. Five years ago the local Education Committee established a residential School for Crippled Children, and Mr. Telford here gives an account of the working of that school, and the results which have been obtained. The school is an institution where educational and surgical treatment are combined. The skilled care and attention which are often required after operation in these cases, cannot be provided in a hospital out-patient department, while the protracted treatment necessary precludes the admission of these children as hospital in-patients. This after-treatment is provided by the residential school, and at the same time the patients receive systematic instruction. The average length of stay in the school is two years, and of 98 cases, 37 were discharged as fit for an ordinary day school, and 12 discharged to work. Experience has shown that the cases which derive most benefit are deformities due to rickets and to infantile paralysis. Cases of mental deficiency, and of advanced tuberculosis with abscesses or sinuses are excluded. The cost of the school has been maintained by the rates, with the assistance of a Government grant, and contributions from parents and local authorities, and a substantial sum derived from the sale of cattle, plants and farm produce.

School Medical Officers, and all who are interested in the problem of the cripple child, should not fail to give this scheme, adopted by the Manchester authority, their earnest consideration.

Physiological Principles in Treatment. By W. Langdon Brown, M.A., M.D., F.R.C.P. (Baillière, Tindall & Cox.) 2nd edition. Price 5s. net.

These suggestive chapters on some of the applications of physiology to medical practice were favourably reviewed in the Gazette on their first appearance two years ago.

The changes in this second edition are mainly in matters of detail, and the sections on movements of the stomach, endogenous purins, intestinal intoxications, and irregular action of the heart have been partly re-written.

The Diseases of Children. By James F. Goodhart, M.D., LL.D. Aberd., F.R.C.P. Lond.; Consulting Physician to Guy's Hospital and to the Evelina Hospital for Sick Children. Ninth edition. Edited by George F. Still, M.A., M.D., F.R.C.P., Physician for Diseases of Children, King's College Hospital; Physician to Out-patients at the Hospital for Sick Children, Great Ormond Street. 1910. (J. & A. Churchill). Pp. 909.

Few words of ours are needed to announce the ninth edition of this world-famous book on the diseases of children. In the preface Dr. Goodhart states that "it is the result of a thorough overhauling of the book from beginning to end by Dr. Still and myself," and of the thoroughness of the revision we have had abundant proof in our perusal of it. The book remains, and will always be, a classic on the subject of which it treats, but we especially wish to urge upon the student who is contemplating the purchase of such a manual, that it is something more than a merely bald recitation of the diseases to be observed in children; it will give him a great insight into the peculiarities and fascination of child-life which is granted by no other book in print. There is only one way to learn of children, and that way is to study them as they live and move without restraint. Sometimes the lessons learnt during the happy hours of health teach us much of what we wish to know in times of sickness. We believe that the great success of the book is due to the life-like pictures of children, both in health and disease, which Dr. Goodhart first outlined with his clever and unerring pen, and to the valuable assistance which he has received in later years from Dr. Still. For the first time, several illustrations have been included in the volume; these have been carefully chosen and well reproduced, so that they undoubtedly increase the value of the book. Since the first edition was published in the year 1885, many authors have produced books upon the same subject, but though the latter may have surpassed the subject of our review in bulk, Dr. Goodhart's work, by brilliancy of description, sound argument and clever portraiture, is still without an equal, and will long continue to be so.

Sport.

Rugby Football.

GUY'S v. OLD BLUES.

It is not often that Guy's are called upon to take the field so early as the very first day of the season, but they had to on Saturday, October 1st, for the above fixture. The ground was of almost midsummer hardness, in fact, a good deal harder than in midsummer of this year, and it is a matter for congratulation that no casualties took place. A good crowd turned up, and the stand was fairly patronised, so that prospects for the coming season are distinctly good.

Punctually to time play commenced, and when once the game had settled down it was evident that Guy's held a big advantage behind the scrum. Saner worked the scrum well, and with Medlock in good form the three's had plenty of chances, one of which was turned to excellent advantage. All the backs handled accurately and well, till Stokes, the last to receive, burst over the line with the first try of the season. Hind converted from the easy place. The home forwards took a little time to get into their stride, and from now to half-time Guy's had more than one anxious moment. The Blues' pack put in much energetic work, and once a score appeared a certainty till Stringer dashed up, and fielding at top speed cleared magnificently.

The second half saw the visitors' attacking movements gradually wane. The home pack got well together, and Tweed and Kennedy, aided on more than one occasion by Parry-Jones, gained ground repeatedly. The Blues' defence was concentrated on Stringer, who managed to elude them finely and get right away, but the last pass was ruled forward. From the next scrum the backs got away again, Digby received, and running out towards Stringer the opposition all waited for the final pass, that never came; Digby doubled inwards, and grounded by the goal-post—a clever try. Hind's kick was charged down. The next two tries fell to the forwards, the first one Kennedy gained, and well he deserved it, for he had shown himself a most untiring forward throughout the game. Good play by the pack and a strong rush carried the leather over again, and Davies was promptly on it and touched down in an easy position. Hind added the extra points, and a good game, which was especially fast considering the high temperature, closed, Guy's leading by 16 points (2 goals, 2 tries) to nil. Team:—

Guy's.—G. E. W. Lacey (back); L. B. Stringer, W. E. S. Digby, W. T. Clarke, A. L. Stokes (three-quarters); C. H. Medlock, J. G. Saner (halves); G. R. Hind, W. S. Stranack, R. S. Kennedy, M. Tweed, O. G. Parry-Jones, A. W. A. Davies, A. B. Danby, C. Gibb (forwards).

Remarks.—It is far too early to criticise, but it was evident that one or two forwards were using their feet very wildly in the early part of the game, repeatedly kicking the ball to the opposing threes. After half-time there was a marked improvement. Kennedy was distinctly good. The inside three-quarters were inclined to hold on to the ball too long, while Stringer should learn to swerve outwards instead of running into the centre of the ground and into the forwards. Stokes should be careful not to pass inwards unless his "backer up" is unmarked. Lacey was in good form.

Association Football.

GUY'S v. OLD EXTERNES.

First Round of the Surrey Cup.

Played at Honor Oak Park on Saturday, October 8th, and won by Guy's by 4 goals to 2.

A hard ground, on which the heavier men were constantly slipping, produced a fast game. The home team lasted well for the first match, although both our opponents' goals came in the last few minutes. The forward line, the same as last year's, except that R. M. Veale displaced Jones, gave a very good account of itself, the passing and pace being excellent.

Birks scored the first goal; this was followed by a fine one from Bergh before half-time. In the second half Bergh and Veale brought our score to 4 before the Externes could reply. Birks, Bergh, and King were the pick of the forwards; Bevis did a great deal of work, but must improve in his centres; Veale is an acquisition, but except on occasions was not quite at his best. Wallis, another freshman, worked hard and well enough at left half to ensure a further trial. Kyle was very good, as were both the backs, the tackling being especially good. Rook had little to do, but had no chance with the two shots that scored. Team:—

Guys.—H. C. Rook (goal): K. J. T. Keer, C. E. Rice (backs); H. B. Neely, J. Kyle, W. T. Wallis (half-backs); R. M. King, V. E. D. Bergh, R. M. Veale, A. H. Birks, S. W. Bevis (forwards).

Papers by Guy's Men.

J. F. Goodhart, M.D., LL.D. Aberd., F.R.C.P. Lond.: Chronic Constipation and its Treatment.—*The British Medical Journal*, 8th October, 1910.

Donald W. C. Hood, C.V.O., M.D. Lond., F.R.C.P. Lond.: Insomnia.—*The Practitioner*, October, 1910.

W. Arbuthnot Lane, M.S. Lond., F.R.C.S. Eng.: The Operative Treatment of Simple Fractures.—*The British Medical Journal*, 8th October, 1910.

Marriage.

FLOWER—LA TOUCHE.—On Sept. 28th, at All Saints Church, Ealing, by the Rev. George A. V. Flower, M.A., Vicar of Greetland, assisted by the Rev. W. W. Oliver, D.D., Vicar of Ealing, and the Rev. Cyril Robins, Vicar of Hounslow; Norman, younger son of George J. W. Flower, of Handford, Yeovil, to Rose Violet, third daughter of the late Lieut.-General W. P. La Touche, Indian Army, and Mrs. La Touche, of "Ospringe," Ealing.

Ed.—A. N. C.

GUY'S HOSPITAL GAZETTE.

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Passim.

MEMBERS of the hospital world will have heard with deep sorrow of the death of His Serene Highness Prince Francis of Teck. His work at the Middlesex Hospital had won him the esteem and admiration of all who have the interests of our charities at heart, and no better memorial to his memory could be conceived than the completion of the scheme for re-endowing the Hospital which he had set out to accomplish.

IN the correspondence column will be found a letter from Mr. T. B. Layton, calling attention to the debate to be held under the auspices of the Clubs' Union and the United Service League, on the subject of compulsory service. This is a matter upon which it becomes more and more necessary for men to have definite opinions, and it is hoped that a large number will turn up to hear and discuss the arguments on either side.

THE Bradshaw Lecture will be given this year by Dr. G. Newton Pitt at the Royal College of Physicians in Pall Mall East, on Tuesday, November 1st, at five o'clock. The subject of the lecture will be "The results of Bronchial Obstruction," and the lecture is open to any students who wish to attend. We would also remind men that demonstrations are now being held at the College of Surgeons by Prof. Keith and Mr. Shattock on specimens from the museum. The next demonstration will he held on Friday, November 4th, at 5 p.m.

WE are asked to remind members of the Guy's Hospital London University Club to let the secretaries know at once if they intend to be present at the Annual Dinner, to be held on November 24th, at the Criterion Restaurant. It will be remembered that Dr. Hale White, the President, has promised to take the chair. There will be no speeches, and we believe that arrangements have been made to provide an entertainment after the dinner of, perhaps, a lighter character than usual.

THE Rugby Football Club Ball, an account of which will be found in another column, was held at Princes, on October 24th. This is the first year in which the Club has given a Ball, but it is hoped—and we feel sure that all who were present will echo the hope—that the function will become an annual one. To Mr. J. G. Saner, the energetic Secretary, who worked so hard and successfully, the best thanks of all are due, and his labours must have been to some extent rewarded by the satisfaction with the arrangements made, expressed by all present.

THERE has recently been issued Dr. Wanklyn's report to the County Council on the action taken by London Sanitary Authorities with regard to cases of pulmonary tuberculosis, which makes interesting reading to those interested in the spread of this disease. In discussing the system of voluntary notification of the disease, the author shows how woefully inadequate it is in revealing anything like the full prevalence

of the malady. That the greater part of the responsibility for this must rest with the medical profession is obvious, and it is interesting to see the reasons given for this lack of notification. Dr. Wanklyn writes as follows:—

> "Among the principal reasons appears to be the belief that no good comes of notification. It appears to be the feeling of many medical practitioners that sanitary authorities, when they have received a notification, are able to take little effective action. Another reason is that when notification is voluntary, patients are apt to object to be singled out for notification. There is the natural disinclination of a physician to run any risk of causing annoyance to his patient—a factor especially apt to operate in a good-class practice. Violation of professional secrecy is also an argument used against the notification of phthisis, and it is stated that cases have occurred in which a patient has first learned the true nature of his illness from a sanitary inspector. Generally speaking, objections may be summed up in this way: that notification of phthisis is apt to put the certifier and certified to a good deal of bother, and in their view may do but little good. Consultants and practitioners alike are apt to resent what is by them regarded as useless intrusion on the part of the sanitary authority into their private business."

That some of the reasons given above against notification are valid ones must be admitted, and the whole question appears to centre round the point: can the sanitary authorities, when notified, do sufficient good to justify the worry and trouble of notification? That they *should* be able to do good is obvious, and further pursuit of the argument brings one dangerously near to the question of the efficacy of our public health authorities! At any rate it is a sufficiently striking fact that a large number of medical practitioners are of opinion "that the sanitary authorities are able to take little effective action when they have received a notification." From Dr. Wanklyn's report it appears evident that the voluntary system is quite inefficient, and that it must be compulsory notification if any good is to be done. From a knowledge of the numerous small ways in which a consumptive can be made less dangerous to his fellows, and by which his chances of a recovery can be increased, the arguments in favour of compulsory notification appear very strong ones indeed; but the matter is one of such interest and importance that discussion on the subject would be welcome.

We are asked to give publicity to the following:—*A duly qualified Medical Man* (a Churchman) is wanted to take up the work under the Universities' Mission to Central Africa, lately successfully carried on by Dr. Robert Howard. The main Station of the Diocese is on the Island of Likoma, Lake Nyasa, where there is a hospital and fully qualified nurses. There are also small hospitals at other stations. The out-patients in 1908 numbered 37,268, and 376 cases were treated in hospital. The Mission is prepared to give a stipend in addition to passage out and home, outfit, board and lodging. The sleeping sickness has not as yet extended to the Lake, but there is a great opening for a man of enthusiasm desirous of working in the cause of Christianity. Application to be made to Rev. D. Travers, Secretary, U.M.C.A., 9, Dartmouth Street, Westminster, S.W.

The following note was recently received by an old Guy's man.

Mr. O——

Cowman for Mr. K——

Sir Will you kindly call on me this morning as I am nearly strangled close to the Vicars door

I remain

Yours truly

Mr. O.

On visiting the patient post haste he was found to be suffering from quinsy, and to be living in the next house to the Vicar!

Revision Classes in Medicine.

The School Examination in Medicine, for qualification for attendance at the Revision Classes in Medicine for the January examination of the Conjoint Board, will be held in the Committee Room of the Medical School on the morning of Monday, November 7th, at 10 a.m. There will also be a *viva voce* examination on Thursday, November 10th, at 3.30 p.m.

The Revision Classes in Medicine begin on Monday, November 21st, and they will be held upon Mondays, Wednesdays, and Thursdays, at 3.30 p.m.

HERBERT FRENCH.

A Note on Local Anaesthesia.

By F. N. DOUBLEDAY.

From time to time, in the use of local anæsthesia for dental operations, I have been troubled by the difficulty of securing an aseptic puncture when inserting the needle used for injections. This has been especially troublesome in dealing with my patients from Messrs. Pascalls' factories. The finely divided powder, composed of carbohydrates, used in the manufacture of sweets forms such an excellent medium for the growth of micro-organisms that painful, inflamed and septic foci frequently marked the spot where puncture of the gum took place. This trouble drove me to the use of a new method of cleansing the gums which has been attended with such happy results that I have been led to publish this note in the belief that it may prove of use to some of my friends who also make extensive use of local anæsthesia. In the first place the gum is sponged over with lysol (2 per cent. solution) on cotton wool; if pockets of gum are present these are syringed out with sterile water and any tartar adherent to the teeth is removed. The gum is then carefully and thoroughly *dried*, after which it is painted over with the following solution:—

Glycerinum Acidi Carbolici } aa partes
Tinct. Iodi. } equales.

The use of iodine for compressing is in line with the most recent methods in use in the surgical wards. The carbolic acid is most useful as an obtundent, preventing the insertion of the needle being noticed, and its use in the form of the glycerinum ensures an absence of the caustic effect of carbolic acid, and the deeper penetration of both drugs into the tissues. I usually order an ounce of the solution to ensure its being quickly used up, and so being constantly fresh. Care must be taken to prevent the iodine from running over the surfaces of adjacent teeth and so staining them. Should this accident occur, the iodine must at once be removed with a weak solution of an ammonium salt. No objection as to time can be urged, the few seconds taken in applying the solution are amply repaid by the results, and with systematic use one gets to apply the solution in the time which it takes the patient to make up his mind which part of the chair is intended for him to rest his head against. The subsequent procedure of injection is as already described in a previous paper (Guy's Hospital Gazette, March, 1907).

The Use of Iodine Solutions for Antiseptic Purposes.

[Reprinted from *Brit. Med. Journ.*]

With many surgeons a practice has recently come into vogue of using iodine for antiseptic purposes. It is always interesting to recall how practices periodically repeat themselves, and how probably this particular one had its origin in the pre-Listerian days. It was within my memory that, as a student at Guy's Hospital, Mr. Thomas Bryant was using iodine solutions at the time when carbolic acid solutions were being introduced by Lister, and being very generally employed by all who were then following his methods. To make sure that my memory served me truly, I wrote to Mr. Bryant on the subject, and received the following reply, which I think may interest many who have revived this old custom:—

Kensington, W.,
September 23rd, 1910.

My dear Maylard,

You are quite right in saying that the use of the solutions of iodine in surgical antisepsis was generally employed by me in 1876 in the treatment of all wounds and most operations, but not in the way you mention—by the local application of the solution of iodine to the skin of the part preparatory to operation. If you will refer to the fourth edition of my book on *Surgery*, published in 1884, vol. i., when Lister's splendid work was first introduced, you will find on pages 23–24 that I had adopted the use of iodine five or six years before, and I may add have adhered to its use with some small modifications up to 1908, when I retired from practice—a period of forty years. I was led to use iodine as an antiseptic from having acted as dresser to Mr. Aston Key in 1850, when Guy's, with all the London hospitals, had a plague of hospital gangrene; and Mr. Key allowed his dressers who had charge of those cases to use the local application they thought to be the best. I selected iodine, and I say now that the results obtained in the treatment of gangrene were better with iodine than with any other drug.

Upon this experience, acquired twenty-seven years before, in 1850, the use of iodine as an antiseptic for general purposes naturally came before me in 1872; and I am pleased to express the opinion, after forty years' experience, that it is without doubt the best antiseptic drug surgeons of the present day possess.

Among its other advantages, iodine in the form of a solution can always be obtained in any chemist's shop. The lotion may be used as a spray or other-

wise, with or without a sponge. As an antiseptic it is excellent, and when warm has a marked tendency to arrest capillary bleeding or oozing. I have always made the iodine lotion by adding its strong solution to water to render it of a light sherry colour, and in septic cases I make the solution of a darker colour. In recent years, in cases of bad compound fractures and septic wounds, I have used iodine in the form of iodol, finely powdered, with boracic acid in equal parts, dusting the wound inside as well as outside with the powder before it is finally closed and dressed, using a dry dressing of some antiseptic gauze to cover the whole. Under this treatment my results have been very good—my dressers used to say that they were better than my colleagues'—but I am satisfied with saying that they have been good. I should like to add that I have used in all my cases torsion of the arteries, which may have done much to bring out the good result.—With kindest regards,

Sincerely yours,

T. Bryant.

Glasgow, Sept. 26th. A. ERNEST MAYLARD.

Correspondence.

To the Editor of Guy's Hospital Gazette.

Universal Military Training.

Dear Sir,—On November 10th, at 8 p.m., a debate will take place under the auspices of the Students' Club and of the National Service League. It will be held in the Smoking-room, and everyone should turn up when such an important subject is being considered. Dr. Hale White will take the chair, and Colonel R. Nugent, C.B., will move this resolution, "Universal Military Training for home defence is necessary for the safety and welfare of Great Britain, and for the peace of the world." Mr. J. A. Ryle will oppose. Anyone who wishes to speak for the motion should give in his name to me, or against the motion to Mr. Ryle. The debate, however, is to explain the views of either side to those who, as yet, know nothing of the subject, and therefore any questions that may be asked will be answered to the best of their ability by the opposer and proposer.—I am, yours faithfully,

T. B. LAYTON,
Hon. Sec. Students' Club.

Rugby Football Club Ball.

Dear Sir,—On behalf of the Rugby Football Club, I should like to thank the members of the Ladies' Committee who helped so much in organising the Ball. Mrs. Taylor and her friends have been most enthusiastic, and a great part of the success of the evening was due to their hard work and assistance.—Yours truly,

J. G. SANER
(Hon. Sec. Guy's Rugby Club Ball).

Guy's Hospital, London, S.E.
October 26th, 1910.

Guy's Hospital Dental Society.

The Dental Society held their first meeting of the session on Friday, October 21st, eighty-two members being present. The chair was, of course, occupied by our popular President, H. C. Malleson, Esq., L.D.S., M.R.C.S. Eng., to whom a noisy reception was accorded. The energetic Secretary (Mr. H. D. Shore) was then called upon to read the minutes of the last meeting, following which, the election of a member of committee to represent the last entry was entered upon. Mr. Fred. Hopson was, almost unanimously, chosen.

The President then delivered his inaugural speech, which is here given :—

Gentlemen,—At this the first meeting of the Guy's Hospital Dental Society it is customary for the incoming President to deliver an inaugural speech. But before doing this, I must offer you my thanks for the great honour you have bestowed on me in electing me your President for the coming academic year.

Nine years ago, when I sat on the benches now occupied by you, I little thought, and I am afraid I did not aspire, to occupy the proud position I now hold as your President.

Last year, under the Presidency of my friend Mr. Aubrey, records were broken of the average number of men attending these meetings, and also at one meeting the attendance reached 100 members present

This year we have a very keen secretary in the person of Mr. Shore, and we have also an excellent committee. Now, gentlemen, we must go one better, and lower the records.

At the Annual Dinner held last February, 195 members and friends were present; this year we hope to get over 200 men to turn up.

A little while ago it was suggested that we should make a change from the place at which we usually hold our dinner. Well, your Secretary went to a good deal of trouble to find another hall sufficiently big to accommodate us. There was very little choice, and after looking at the only likely place, we both came to the conclusion that it would be too small owing to numberless pillars all round the room, which would break up the usual pleasant cheeriness of our dinner. We shall, therefore, have to content ourselves with the usual meeting place in Shaftesbury Avenue.

Coming to more serious matters, I would wish all those men who are shortly going up for their exams., both in the final and first professional, every success, especially for their own sakes, and also for the prestige of the Guy's Hospital Dental School.

To those in their first year, and especially to those who have just entered, I would say be thorough in your work, do a little well rather than a lot indifferently; if at first you find that the amount of work you do seems small, if that little has been well done, you will very quickly improve, and you will have fewer failures than the man who gets along faster, but who does his work in a slovenly way. If I may be allowed to give you some advice, I would say, be certain of every step in the work you are doing, because if you do the first step badly, however well the second may be done, the chances are that it will be spoilt by the inferiority of the work of the first, or you will find that at the last the whole thing collapses.

Don't say to yourself "It'll do," but say "Is it the *best* I can do?"

Above all things, combine with your good work sympathy, patience and tact, for it is these things that will make you successful practitioners in the future.

As to the prospects of the Dental School, by this time next year I believe we shall be occupying our new and enlarged quarters. As you know, the Governors have consented to the removal of the Chemistry and Physics department to new premises built above the present Physiological department, and we shall then occupy, after certain alterations, the whole of this block of buildings. When this is finished we shall have a dental school second to none in London or the provinces.

As to the topics of most interest to the dental profession, the relation of the registered to the unregistered practitioner, and the treatment of the teeth of children attending the public day schools, are, I suppose, the most important. As to the first, most of you are as conversant with the facts as I am, so I shall not weary you with the question of the proposed legislation.

There is a view held by a good many men, and I think it is a very sound one. It is that the best way to prevent the quack from doing the harm which he now does with impunity is to educate the public to know the difference between the skilled practitioner and the unregistered quack. It is this public opinion which will do more to further our aims than anything else.

As to the second question of the treatment of school children, it is twenty-five years ago since the matter was brought to the notice of the Dental profession, and it is only in the last two years or so that any strides have been made in the matter.

There are a good many obstacles to contend with, and the principal one, I suppose, is the question of remuneration for the dental surgeons undertaking the work.

To find the money for this great work is the subject now exercising the minds of those most interested in it. Either it must come out of the pockets of the parents or it must be supplied by the Education Authorities. In the former case, I suppose it would then be impossible to make the treatment compulsory, which of course would spoil the whole undertaking. In the second case the educational authorities would have to get it from the rates. Now, the rates are already very high, and the local authorities as now constituted would refuse to increase the rates.

Another thing is the small number of dentists willing to undertake the work in comparison to the number of children to be treated.

No doubt in time these obstacles will be surmounted and the results seen will be far beyond our expectation. The child will start life with good dentures, and a corresponding improvement in general health and physique.

Now, gentlemen, I must thank you for the forbearance you have shown me in listening to, I am afraid, rather a poor discourse. I am looking forward to spending some very enjoyable afternoons with you, and I hope I shall be able to carry out my duties as your President to your satisfaction.

Casual communications were then sent up, amongst which were some extremely interesting exhibits brought by Mr. W. E. Tanner, which included "one of the first continuous gum cases made in this country. It was made for an edentulous upper, and its base consisted entirely of platinum; also dentures carved out of bone, and then coloured; four cases of exostosis; an enamel nodule; one case of a rudimentary root; and a dental bridge made by a Kaffir." Casual communications were also shown by Messrs. H. Barge, H. L. Messenger, I. Samuels, H. Shepherd, and S. J. F. Webb.

The President then invited Mr. Colin Wade to read his paper, entitled "The Dentist and the State," which proved a very interesting paper, and one that lent itself to much discussion. Apart from the Socialistic tendency of the paper, the questions of dental cliniques and the treatment of school children's mouths were reasonably entertained.

In the ensuing discussion the Socialistic ideas were seconded by that noted champion of the red flag, Mr. Neft, who, in turn, was strongly attacked in a very able and patriotic speech by Mr. W. E. Tanner.

Mr. W. F. Ollis rose to discuss a point of history, and Mr. F. Bocquet Bull emphatically objected to the term "septic" as used by Mr. Wade in relation to the surgeries of British dentists.

Mr. Morris gave a short *résumé* of how they managed, as regards children's teeth, in South Australia, and dwelt upon results that he had seen, and that he knew had sprung from educating the public in dental hygiene and dental politics.

The President, Mr. A. L. Saul, and the Secretary also took part in the discussion.

Mr. Wade then briefly replied.

Upon the President announcing that a paper would be read on "Casting," by Mr. Williams, on November 11th, the meeting closed.

NORMAN S. HEEGAARD WARNER.
(*Pro* W. A. Thompson.)

The Guitar.

In one of the many parts of London which go by the vague name of the "West End," there is a street which I shall call "Walington Gardens." "Walington" is not the real name, but it will serve my purpose. It is called "gardens" because no doubt it sounds more refined than "street." The rents are higher in consequence. I put up my brass plate there for a brief time before settling finally in the country. "John Norcross, M.D.," shone in large letters from the middle of a dark green door. I resided there for about eighteen months, and it was towards the end of that period that the incident that I am about to relate occurred. When I first took my house I noticed that there was another to let at the further end of the street. It had been untenanted for some years on account of the grim story of the suicide of the last tenant, which gave the house an unpleasant name. One end of Walington Gardens ran into a solemn-looking square, and the other joined a busy thoroughfare. On the East side of the street the houses were high and more or less imposing by comparison with those on the opposite side. The East side considered itself *the* side of the street, and the tenants were superior people. Nobody on the East side would confess to knowing anyone on the West side. A gulf seemed fixed between. The East frowned on the West, and the West laughed in return. I certainly lived on the West side, but the neighbours were charitable enough, I believe, to look upon me as a sort of missionary. The characters of the East side people were above reproach. Most of them went to church in the early morning while the blinds were still down on the opposite side. At night the good folks went early to rest, to shudder in bed, perhaps, at the sound of cabs dashing up to the houses across the street at all hours of the night; but the "Evens," as their neighbours called them, were very curious about the gay doings of the "Odds," and often peering eyes could be seen gazing from the crumpled edge of a drawn blind searching the flaming windows of the opposite house. Dainty broughams would hover at several dainty houses on the wild West side, and dainty ladies would drive away of an evening in wondrous toilettes to the admiration of the errand boys who loitered in the street. Sometimes a song of Italy would enliven the street, as a musician would throw open his windows and hold his neighbours spell-bound. The piano on the West side was variously treated. A master of music would show his power over the instrument and give of his best, while at the other end of the scale the latest ditty of the "Halls" would range up and down the "Odds" at all hours of the day and night. Such describes Walington Gardens. One day, an interesting event happened. The house, "No. 25," so long unoccupied, was let, and the most astonishing thing about it was that the tenant was an old lady from the country, who seemed to have dropped into the neighbourhood by accident. Forthwith her presence was immediately noted as an oasis of respectability among the "Odds."

As a medical man, I naturally took an interest in the new tenant of No. 25, as a possible patient. I had not long to wait. A few days later I was sent for by Mrs. Raines, for such was the newcomer's name. She was a quaint old lady, with old-fashioned grey curls, and a lace cap. She was rather over-done with the excitement of moving into her new house. Beyond a weak heart, not unnatural at her age, there was not much amiss with her. I cautioned her to keep very quiet for a few days, and, promising to call again, I withdrew. Late that night, however, I was rung up for the new tenant of "No. 25."

I lost no time in obeying the summons, and found the old lady sitting up in bed, and greatly agitated.

"Oh, Dr. Norcross," said Mrs. Raines, "I had only dropped off to sleep when I was awaked by the twanging of a guitar in the house; I rang my bell for the maid—I keep two. Mary, the cook, came to me. I said, 'There must be someone in the house,' for I still heard the sound of music. I can't hear it now," she added.

I turned towards the fat individual with blanched face, who had conducted me upstairs, and asked if she had heard anything, and for reply received a decided negative.

"Don't you think it was a dream?" was my next question.

"Oh, dear no. I am sure I heard it. Please will you look if there is anyone in the house?"

"Certainly," I replied, and with the aid of the cook I proceeded to explore the house. It was a small house of nine rooms, like my own further up the street. I explored each room. On the drawing-room floor the rooms led into one another by folding doors, and on the ground floor the dining room was practically part of the room at the back, the division having been abolished. The house was prettily furnished, with signs of departed splendour in a miniature way. As I looked round, I saw a pair of curtains in the back drawing-room window of red and yellow striped silk. I remarked to the maid that they were the Spanish colours.

"Yes," she said, "They belonged to the late tenant, who was Spanish. Missus took them over with the fixtures."

"A musician?" I asked.

"I don't know, Sir," said the cook vacantly.

Back in the old lady's bedroom, I reported that there was no one in the house except those entitled to be there, and expressed my opinion that probably the sound of the guitar was the result of a dream. Mrs. Raines, however, was very obstinate on this point, and maintained that she heard distinctly the twanging of a guitar coming from below and gradually ascending the stairs.

"Well, well," I said, "Whatever it was, you don't hear it now. Your nerves are, however, excited. Let me prescribe some sedative."

The old lady agreed to the suggestion and let me depart.

When I returned home I began pondering over the occurrence, and recalled to mind the story of the late tenant having committed suicide. She was Spanish, it appeared, and possibly played the guitar! Could it be—Nonsense, I thought, the house cannot be haunted!

The next day I asked a neighbour if he knew anything about the late tenant at "25," and got the information that she was a beautiful Spanish woman who used to play the guitar at a music-hall, and who latterly possessed a brougham, two toy dogs, and dressed in wondrous style. One day she committed suicide by poisoning herself with morphia. She was known as "Senorita Victoria." This was all the information that I could get about the lady.

A few days later I was again rung up at midnight for Mrs. Raines. As I entered the house I started, for I distinctly heard the sound of a guitar played softly. I am not a superstitious man, but there certainly seemed something uncanny about this music. The maid was busy with the door latch, and apparently heard nothing. As I went up the stairs the music ceased. I went into the drawing-room where the electric light was still on. I looked round keenly. There was no one there. Perhaps it was imagination, but I thought I saw the striped curtains move. I stepped forward and called out, "Who's there?" There was no reply. I seized hold of the curtains, and pulling them apart, saw there was no one behind. I noticed the window was fastened.

"Bah!" I said. "Mere imagination!" Upstairs I found Mrs. Raines, again in a state of excitement.

"The guitar, the guitar!" she kept saying. "I've heard it again!"

I tried to pacify her, but I found it impossible to convince her she had not heard it, so at last I said I had heard the guitar too.

"*You* heard it?" said Mrs. Raines, with astonishment.

Then I told her what my experience had just been. We looked at one another in a nervous way without speaking. The situation was an entirely novel one for me, but I felt it had to be faced. I resolved to solve the mystery at all hazards. Taking the old lady's trembling hand in mine, I said—

"Will you let me investigate this matter myself? Let me come here every evening."

Mrs. Raines gladly consented to this proposal, and I was suffered to go away after I had persuaded her to take another draught.

The next evening, about ten o'clock, I started ghost-hunting. It was my first experience, and I confess I did not quite enjoy the prospect before me.

I hardly know how long I sat alone in the drawing-room. The electric light was full on, and the dainty little apartment looked very pretty with its quaint gilt mirrors and pretty flower-pattern paper. I sat in an easy chair of yellow damask silk, reading a novel of the drowsy kind, which had nearly accomplished its agreeable purpose, when I distinctly heard a musical sound, in discord with the tinkling cab bells in the street. I listened intently. Yes—the music became louder. It was a guitar, undoubtedly! At first it was difficult to locate it. It seemed at one moment outside the door, and at another overhead. The cab bells ceased in the street, and there was a lull in the distant rumble of the main road close by. The music seemed at the door of the drawing-room. Was some one entering the room? I glanced involuntarily at the electric switch placed on one side of the folding doors. In a moment I had extinguished the light, and stood silently by the wall. I heard the handle of the door move, and knew the door was open. Something swept past me like a cloud, and brought with it a delicious perfume, pungent and intoxicating. The room was filled with music that seemed to accompany dancing feet. I could feel the movement of the air about me, and heard the sound of quick breathing as the invisible dancer moved about the room. Then I heard the rumble of the distant traffic in the main road commence again, and the faint sound of a cab bell outside drawing nearer. These common sounds seemed to nerve me, and I switched on the light. As I did so the music stopped. I can swear *I saw the silk curtains moving!*

"Who's there?" I cried, as I rushed forward and pulled them apart. There was no one there! The window was bolted. I glanced quickly round the room, and saw I was alone!

As the cab in the street thundered by with its jingling bells I heard a faint scream in the room above me. In a moment I had rushed up the stairs, and entered Mrs. Raines' bedroom. The old lady was lying back on the pillows in a state of collapse, her pale blue eyes fixed upon me with a stony stare. Her face was ashy pale. Her lips moved feebly in a final effort of speech. I caught the words "*I heard.*"—Then her head fell forward, and she was dead.

* * * *

To a nephew who came up from the country I explained that Mrs. Raines had died from heart failure, the result of a nervous shock induced by a vivid imagination, which made her think the house was haunted. He was quite satisfied, but shrugged his shoulders complacently at the suggestion of the supernatural. I did not offer to tell him my experiences, and the servants cleared out of the house without comment, on receipt of a month's wages.

I am told "No. 25" is still to let.

FREDERIC VICARS.

THE EDITOR will, at all times, be glad to consider Articles or sketches, provided that they are accompanied by the writer's name and address, not necessarily for publication. Payment is a matter of arrangement, and the fees that the GAZETTE *can offer are merely nominal, but if the writer desires any remuneration that fact should be stated. Authors who desire reprints of their papers should make their own arrangements with the printers when they return their proofs.*

Pupils' Physical Society.

The second meeting of the present session was a Pathological evening, and was held in the Wills Library on Saturday, October 15th. Mr. Marshall took the chair. Thirty-nine members were present.

The following pathological specimens were shown:—

1. Periosteal sarcoma of the tibia — Mr. Gardiner.
2. Epithelioma of the leg ... — Mr. Bennett.
3. Carcinoma of the rectum ... — Mr. Plumptre.
4. Hypernephroma ... ... — Mr. Todd.
5. Hypernephroma ... ... — Mr. Poulton.
6. Ruptured aorta ... ... — Mr. Allen.
7. Tuberculous cæcum ... ... — Mr. Poulton.
8. Hypertrophy of labia from lymphatic obstruction ... — Mr. Dunderdale.
9. Carneous mole ... ... — Mr. Dunderdale.
10. Two specimens of carcinoma of the uterus ... ... — Mr. Dunderdale.
11. Papilliferous cyst of the ovary — Mr. Dunderdale.
12. Fibroma of labium ... ... — Mr. Dunderdale.
13. Meningomyelocele and hydrocephalus ... . — Mr. Davies-Colley.
14. Gangrenous senile endometritis ... ... — Mr. Poulton.

The following gentlemen took part in the subsequent discussion:—The Chairman, Messrs. Maxted, Townrow, Neville Cox, Davies-Colley, Berry, Penny, Todd, Stout, Captain Gray, and the Secretaries.

The next meeting will take place on November 2nd, when a discussion on "Faith Healing, or the Mental Factor in Disease," will be held. Several members of the staff have promised to take part, and a large attendance is hoped for.

Guy's Hospital Debating Society.

At a General Meeting of the Debating Society held on June 22nd, the following business was transacted:—

1. Election of Officers.—Dr. Shaw was re-elected President, and last year's Vice-Presidents, Drs. Fawcett, Pembrey, and Spriggs, and Messrs. Ormond and Thompson were also re-elected.

On the resignation of Mr. Cook, Messrs. Ryle and Barrow-Clough were appointed Secretaries and Treasurers for the ensuing session.

The following were elected members of the Committee: Messrs. Sandison, Cook, Marshall, Mullally, Scott, and Bennett.

2. The accounts were approved and signed.

The first meeting of the Society will be held to-night, Saturday, October 29th, in the Club Smoking Room at 8 p.m. All members of the Clubs' Union are members of the Debating Society, and are entitled te attend and take part in the discussion. Freshmen particularly are invited.

Subject.—"That in the opinion of this House a system for the payment of Members of Parliament should be introduced."

Physiological Society.

A General Meeting of the Physiological Society was held on Monday, October 17th. The following officers were elected for the year:—President: Dr. Pembrey. Vice-Presidents: Drs. Boycott, Cameron, and Hertz, Messrs. Hughes, Thompson, Kennaway, Ryffel, and Layton. Hon. Sec. and Treasurer: H. W. Evans. Committee: Messrs. Wills, Gould, Barrow-Clough, Hancock, McKay.

The next meeting will be held on Monday, October 21st, when a paper entitled "Organs of Embryonic Nutrition," will be read by Mr. C. H. Gould.

All men in the Dissecting Room are invited to join the Society. Fortnightly meetings are held on Mondays, when a member reads a paper which is followed by a discussion, in which anyone present may take part. Tea and smokes are provided. Subscription, 2s. 6d.

Appointments.

Medical School Appointments.

The following appointments have been made by the Treasurer upon the recommendation of the Medical Council:—

Clinical Assistants in Medical Wards.—Messrs. R. Stout, G. R. Hind (Dr. Hale White); H. G. B. Blackman, M. M. Munden (Dr. Pitt); A. J. McNair, N. Mutch (Sir C. Perry); A. Sandison, H. V. Leigh (Dr. Shaw).

Clinical Assistants in Surgical Wards.—Messrs. P. J. Watkin (Mr. Symonds); A. D. Vernon Taylor (Mr. Lane); J. A. Delmege (Mr. Dunn); H. N. Eccles (Sir A. Fripp).

Ophthalmic Dressers.—Messrs. J. M. Jarvie, C. D. Killpack (Mr. Eason); N. S. Carruthers, W. T. Chaning-Pearce (Mr. Ormond), November 1st. A. H. Todd, A. M. Bodkin (Mr. Eason); J. L. Stewart, W. M. Langdon (Mr. Ormond), December 16th.

Surgeons' Dressers.—Messrs. C. Aldis, C. A. R. Gatley, T. B. Heaton (Mr. Symonds); W. J. D. Smyth, F. Tooth (Mr. Lane); T. P. Cole, G. W. B. Garrett, M. Pern (Mr. Dunn); E. C. Peers, W. S. George, D. A. Davies (Sir A. Fripp).

Externs.—P. J. Monaghan, A. H. Todd, W. M. Langdon, R. S. Bennett, W. S. Hyde (November). T. S. Allen, E. R. Hart, V. Glendining, W. S. Lacey, J. B. Hance (December). E. W. Blake, H. P. Warner, G. T. Foster-Smith, F. G. Lloyd, G. Marshall (January).

House Committee Appointments.

The following appointments have been made by the House Committee upon the recommendation of the Medical Committee:—

Obstetric Resident.—Mr. C. Witts.

Clinical Assistant in Aural Department.—Mr. K. H. Digby.

Anæsthetist to the Hospital.—Mr. K. H. Digby.

Tuberculous Disease of the Hip-Joint.

CLINICAL LECTURE BY Mr. R. P. ROWLANDS.

Gentlemen,—Tuberculous disease of joints is very common, especially in the children of the poor. Its insidious onset too often delays treatment, and its tedious course leads to carelessness and neglect which are attended by the most serious consequences. Hip-joint disease is the most common and by far the most serious. I have, therefore, chosen it for the subject of my lecture. In your practice you will meet many of these cases and you will be judged by your results. You will have it within your power to prevent deformity, suppuration, and death. Moreover, you may make a potential cripple into a useful member of society. You have only to look about you to see the other side of the picture, for the results of neglect and carelessness are evident enough. You will see many weakly and stunted cripples who have just managed to exist through years of misery, but are now unable to earn a decent living. They are often dependent on their friends, or charges on the community. Others, often more fortunate, have died of the disease. Think of the waste of it all, and remember that nearly all this misery and waste is avoidable by careful treatment. You have to impress upon the parents or guardians the seriousness of the disease and the grave consequences of its neglect. Then they may think it worth while to keep a diseased limb at rest for, what appears to them to be, an unnecessarily long time.

1. *Ætiology.*—There is often some primary focus of tuberculous disease such as caseous, mesenteric or mediastinal glands. In such a patient a slight injury or strain of the neck of the femur may determine the deposition of tubercle bacilli in the damaged part. It may be remembered that the chief epiphysial line of the upper end of the femur, and a part of the growing diaphysis are within the capsule of the joint. This is the most vascular part, and the one most subject to injury. The deposition of tubercle is followed by chronic inflammation, and the formation of tuberculous granulation tissue which gradually replaces the cancellous bone of the neck and head of the femur. In the course of time the infection may spread into the hip-joint, the synovial membrane of which becomes tuberculous. In adults, and some children, the disease starts in the synovial membrane. The disease also spreads to the acetabulum, the floor of which may be perforated in bad cases. A pelvic abscess may then develop. Soft sequestra are not uncommon in the hip-joint, portions of the head of the femur being isolated by the tuberculous granulation tissue. Destruction of the head or of the acetabular rim may lead to pathological dislocation of the femur on to the dorsum of the ilium. Fibrous or bony anchylosis may ultimately take place between the femur and the ilium or acetabulum.

2. *Signs and symptoms.*—The symptoms and signs of tuberculous hip are so insidious that they are often overlooked until the disease is well advanced. A child may complain of pain in the knee after walking or running. Later on he has starting pains at night. These are due to the relaxation of the muscles as the patient falls to sleep, and the painful movement of the joint which this relaxation allows. The child looks pale and ill, and often loses his appetite. One of the earliest signs is limping when walking. This is often seen long before the child complains of any pain. Some flexion and limitation of movement of the hip soon develop. Abduction with apparent lengthening may be noticed, and later adduction with apparent or even real shortening develops. Later on the shortening may be a serious thing in itself, and it is important to remember its main causes.

a. False shortening.—Some of it is due to adduction and flexion of the thigh. This is often called false shortening, because it can be corrected by straightening the limb.

b. Real shortening.—Some of the shortening is due to destruction of the head and neck of the femur, dorsal dislocation, want of growth of the femur from disease and disuse, and of the whole limb from disuse.

It must be remembered that all shortening is of importance to the patient, for he is concerned with the elevation of boot that is necessary to make his pelvis level and his gait comfortable. In some cases following excision of the hip-joint in childhood I have known this shortening to amount to eleven inches. An abscess arising from the hip-joint may burst in front of the outer side of the thigh just internal to the tensor fasciæ femoris, or it may travel down deep to the ilio-tibial band and burst low down on the outer side of the thigh. In other cases an abscess forms in the buttock. In others the pus may track behind the femoral vessels and present on the inner side of the thigh. In others, again, a pelvic abscess may travel up and bulge above Poupart's ligament, or it may burrow downwards in the ischial fossa and

burst near the anus. Septic infection of these abscesses or sinuses may occur, leading to acute or chronic septicæmia with lardaceous disease. In some cases general tuberculosis develops.

3. *Diagnosis.*—It is very important to know how to examine the patient suspected of disease of the hip. This can be done without hurting the patient to any appreciable extent, and if properly carried out it can be trusted to give fairly accurate information. As the child lies on a couch slight wasting of the thigh can be seen. Eversion, abduction or adduction of the limb can be noticed. The thigh which is supposed to be healthy is first flexed to the full extent, so that the knee touches the chest. This corrects all lordosis of the lumbar spine and displays any slight flexion of the diseased hip without causing pain. The amount of flexion is often surprising. Each leg in turn is grasped at the ankle and gently rotated while the pelvis is watched. Rotation is limited quite early in hip disease, and the pelvis then tends to move with the thigh. An attempt is then made to flex the diseased hip. Passive movement in this direction is limited. There is some tenderness and fulness over the front of the hip-joint. When the patient is turned over into the prone position there is some flattening of the buttock on the affected side and diminution of the gluteal fold. In some cases the onset of hip disease appears to be much more sudden, and then the difficulty of diagnosis is considerable. In these cases it is probable that an abscess in the neck of the femur has burst into the hip-joint, leading to acute arthritis. The temperature, however, is rarely raised so much as with acute septic arthritis, nor are the local signs so severe. Like any other joint, the hip may be sprained or bruised, and the symptoms of early hip disease may be simulated by simple synovitis of the joint. It is very important not to mistake this condition for tuberculous hip. Rest in bed for about a week or a fortnight clears up all the symptoms. Tuberculous disease of the great trochanter, being extra-articular, does not lead to any limitation of rotation of the joint, or to any real or false shortening. It may, however, lead to limitation of flexion, especially when pus has formed and has collected under the gluteus maximus. Any gluteal abscess limits flexion of the hip, but a careful examination of the buttock serves to reveal its presence. An X-ray examination and local thickening may give evidence of disease of the great trochanter. You must remember that tuberculous disease of the bursa over the trochanter is fairly common; the way to distinguish it from hip disease has just been pointed out. In rheumatic fever more than one joint is usually affected, and there are other signs of rheumatism. Pneumococcal infection rarely occurs except as a sequel of pneumonia, which gives a clue to the diagnosis. Generally there are several joints affected to a variable extent. The affection of the hip is more acute and severe, and there is more swelling than is seen with early tuberculous disease. Everyone probably knows how common it is for the parents, and often others, to apply a splint to the knee when the disease is really in the hip. I have known several cases of early hip disease mistaken for infantile paralysis. This mistake is easily avoided by testing the mobility of the joint in the manner already described. There is no limitation of movement in infantile paralysis. In young adults gonorrhœal hip may be mistaken for tubercle, but it is only necessary to remember the possibility of the mistake and to seek the cause of the infection. In older people osteo-arthritis is sometimes difficult to distinguish from tuberculous disease of the hip, but generally there are other joints affected, and an X-ray examination may help. It is not uncommon for young girls who have seen a patient suffering from tuberculous hip to mimic the disease. The diagnosis is then very difficult, especially as there is nothing to prevent an hysterical patient developing tuberculous disease of the hip-joint. Other symptoms of hysteria, and particularly careful and repeated examination of the hip, if necessary under an anæsthetic, may clear up the diagnosis. Usually there is no limitation of rotation when the limb is extended and grasped at the ankle, for the patient does not understand the significance of this examination. Again, when the healthy hip is fully flexed, the one which is supposed to be diseased may remain extended on the couch. Moreover, the symptoms and signs vary from time to time, and the movement of the hip under an anæsthetic is perfectly free in every way, and a careful X-ray examination shows no evidence of disease. But it must not be forgotten that an X-ray examination hardly ever shows any signs of early disease of the hip-joint, so that a negative report is not of much value in excluding real hip disease. In adolescents, sacro-iliac disease is sometimes mistaken for hip disease, but it can be distinguished by the local tenderness over the joint, the pain elicited by separation and approximation of the anterior superior spines, and especially by the absence of any limitation of rotation of the hip-joint. Flexion of the hip sometimes results from induration of the psoas muscle due to spinal caries; it is therefore

important to palpate the psoas, and to test the mobility of the spine.

4. *Treatment.*—Within my memory the treatment of tuberculous joints has changed a great deal. When I first came to Guy's about eighteen years ago excision of the hip by the anterior incision was very common. Everyone seemed to be fascinated by the apparently brilliant results of the Barker operation. Since then excision of the hip-joint, especially in children, has properly fallen out of favour. The results that seemed to be so brilliant were marred by frequent recurrence of disease, formation of sinuses, and the gradual development of a crippling amount of shortening. Gradually there has been a reversion to the conservative treatment, which, if thoroughly carried out, affords the best results in tuberculous disease of the hip-joint. More recently, Bier's treatment and tuberculin injection have each created a diversion, but all surgeons who have had a large experience of these cases know that neither of these methods offers anything like the same prospect of recovery as the treatment by rest. It is clear that they can never replace the latter. It is an open question whether they may be usefully combined with it. Congestion of the hip-joint is not easily carried out. It is more applicable and is undoubtedly of more use for other tuberculous joints, such as the wrist. I am convinced that both passive and active movements of the hip are harmful. They increase pain and inflammation of the joint, cause sleeplessness, and depreciate the general health. Moreover, they are not necessary, for mobility takes care of itself once the disease has subsided. During the early stages of the improvement which invariably occurs with rest, the joint becomes stiff, and the uninitiated may think this to be a serious thing. As time goes on, however, the movement returns, and it is not at all uncommon for it to return completely and spontaneously within a few weeks of the removal of the splint, which has been applied for a year. The first consideration is to get rid of the disease, and if this be accomplished movement will return. The earlier rest is adopted the sooner is the disease arrested, and the more the movement obtained. As regards tuberculin injections, it is my experience that they are rarely necessary in the treatment of tuberculous joints, and they may do harm in an indirect way by diverting the attention of the patient and his friends from the treatment that is really important and efficacious. This sometimes leads to the neglect of the rest, which is imperative. For instance, I have known a patient discard her splint because she trusted so implicitly in the tuberculin injections. The result was that the joint got very much worse, only to improve again when the splint was re-applied. The following is the treatment which I generally adopt:—

As soon as the diagnosis is certain the seriousness of the condition is explained to the parents or guardians, and attention is drawn to the grave consequences that may follow neglect. It is necessary to be quite frank with them so that they may really do their part in carrying out the treatment. The child is measured for a Thomas' splint and a long Liston applied until the splint is ready. For a child under six years of age, or for neglected disease, a double Thomas' splint is generally ordered. This provides more complete rest, and is more efficient in correcting or preventing deformity. The longitudinal bars of the splint are placed posterolaterally so that the child need not lie upon them. A pelvic band is also provided. This girdle is an important aid in procuring slight abduction of the diseased hip. It encircles the body a little below the crest of the ilium. The bands around the thigh and pelvis are made of malleable iron so that they can be moulded by the surgeon, but not changed by the patient. The longitudinal bars are so stiff that the patient cannot possibly bend them. I have seen splints soft enough to allow considerable flexion at the hip joint. The splint is well padded and the pelvic part is covered by some waterproof material. Children over six years of age are fitted with a single Thomas' splint and are allowed to get about on crutches when the disease is settling down. Younger children are rarely safe with crutches. Moreover, they waste a good deal of energy in trying to walk about. They are made to live an open-air life as far as possible. They are carried or wheeled out of doors or live near an open window, but not in a draught. They need not lie horizontally, for the couch can be placed obliquely with the head a little raised without producing any flexion of the hip-joint. This position is more interesting for the patient, who can eat more easily and see better. The splint is never removed except for washing. All the straps are unbuckled and the splint is pulled downwards by grasping the metal bar which separates the leg pieces. This hardly disturbs the patient and produces no painful movement of the hip-joint. The rest provided by the splint is never absolute, but experience shows that it is sufficient. The nutrition of the muscles of the leg and back is preserved by active and passive movements and

gentle massage carried out regularly every day. It is not wise, however, either to massage or to move the thigh on the diseased side, for this often aggravates the disease and sends the temperature up. The upper limbs move freely enough and may be trusted to take care of themselves. The value of the rest is two-fold.

a. Local rest is necessary for the healing of the joint.

b. The conservation of energy.

The normal child is so restless during his waking hours as to waste a great deal of his limited energy. When he is compelled to be at rest this waste is avoided, and as a rule the child can be made to eat as much as when he is running about. There is at first a loss of appetite, but the relief of pain often brings a greater gain. The effect of this conservation of energy is seen in the very rapid growth and improved nutrition of the child, and I believe also in the earlier healing of the joint disease. In addition to rest, the child is made to lead an open-air life, and is fed up as much as possible, especially on fatty and albuminous foods. He is also given cod liver oil and malt or cod liver oil and iron. The provision of nourishing food is difficult for the children of the poor in London, but even with these disadvantages tuberculous disease of the hip does remarkably well if the rest treatment is adopted early and efficiently carried out. Under these conditions it is very rare for an abscess to form. I have treated a great many of these patients during the last ten years—first at Shadwell and then in the Orthopædic Department at Guy's—and I have not yet seen an abscess appear in any child in which the rest treatment has been commenced within two months of the onset of symptoms and thoroughly carried out. On one occasion I was greatly puzzled by the onset of suppuration. The boy had been treated for some time at my Out-patients, and then sent for open-air treatment to a nursing institution in the country. After several months the child was brought back with an abscess threatening to burst. On making inquiries it was ascertained that the splint was taken off at night and also at meal times. No wonder suppuration occurred! That a lady who had been trained as a nurse should be so ignorant of the fundamental importance of rest in the treatment of this disease shows how vital it is to impress on the parents and others concerned that the constant application of the splint, both day and night, is essential. Adequate rest is of even greater importance than fresh air. It is of great importance to know how long the rest must be continued. Tuberculous disease of the hip that is at all advanced is not likely to get well under a year. It often takes eighteen months or more. This is only what we should expect if we pause to think of the pathology of the disease. It is a temptation to turn the child loose when the pain and tenderness are gone, but this is not wise. It is safer to wait at least six months from the last night pain and until the joint is becoming supple again. In no case is it wise to discontinue the splint under nine months, and then only under the most careful supervision. The earlier the splint is removed the greater the risk of recurrence of symptoms. If the treatment is started early enough, and carried out efficiently, the great majority of tuberculous hips should get well without shortening or serious limitation of movement. There is often a little wasting of the muscles of the thigh. Unfortunately, many patients are seen and treated too late for anything like a complete recovery. In these there may be some shortening and considerable limitation of movement. In some late cases there are considerable flexion and adduction when the patient is first seen. Then it is wise to get the limb into a good position by means of extension before a Thomas' splint is applied. Other cases are not seen until suppuration is threatening, or has developed. Even in some of them the disease may settle without operation when adequate rest is enforced. When there is a considerable collection of pus it is necessary either to aspirate it through a needle of large calibre passed obliquely, or to make an incision, scrape out the cavity, get rid of any loose dead bone, and immediately sew up the wound again. In such a case in a child excision is to be avoided, for the shortening that necessarily follows it is a serious disadvantage in later life, whereas the chances of arresting the disease are not increased by cutting into fresh bone at the neck of the femur.

Further, the loss of the head of the femur greatly diminishes the supporting value of the limb, and it is rare for the latter to be able to bear the whole weight of the body for more than a moment, so that although the shortening may be compensated, the characteristic limp remains. It may be urged that for bad cases excision is better than conservative treatment because more movement and less deformity follow it. But in the lower limb stability is of greater value than mobility, especially when movement is apt to be excessive, so that the femur glides up and down upon the ilium as the patient walks. As regards deformity, this can be minimised by the constant

use of a suitable apparatus during conservative treatment. When the instrumental treatment is neglected, deformity develops whether excision has been done or not, and adduction is especially severe after this operation unless special care is taken to prevent it. When all signs of inflammation have disappeared for several years a great deal can be done to correct the deformity that is seen in neglected cases. The femur is divided below the great trochanter so that flexion and adduction of the limb may be corrected. In some cases it is necessary also to divide some of the adductors near their origin and the tensor fasciæ femoris, and other shortened structures in front of the hip. The limb is then fixed in a slightly extended and abducted position in a plaster of Paris spica. In this way a shortening of six inches may sometimes be reduced to one and a half inches, and a hideous high boot or other elevating apparatus replaced by a cork inside a boot. The various secondary deformities of the spine are corrected at the same time. Infected sinuses with hectic fever are fortunately getting less common than they were some years ago, owing to the more general and earlier adoption of conservative treatment. The essential thing in these cases is to provide free drainage, and with this object it may sometimes be necessary, especially in adults, to remove the head of the femur. A suitable vaccine may hasten the healing of the sinuses. Some years ago amputation was not uncommonly performed for chronic suppuration with threatening lardaceous disease. Unfortunately even this grave operation often failed to get rid of the disease, which frequently affected the pelvic bones. Further, you may remember that it is very difficult both to get and to fit a useful artificial limb after amputation at the hip-joint. It is my firm conviction that conservative treatment efficiently carried out should minimise, if not prevent, deformity, prevent suppuration and septic infection, and lessen the risk of general tuberculosis. Amputation and even excision of the joint should be regarded as depressing indications of failure. Let not that failure be due to any want of care on our part either in the actual treatment of the disease or in drawing the attention of the parents to the importance of their loyal and patient co-operation.

Papers by Guy's Men.

M. S. Pembrey, M.A., M.D. Oxon.: The Function of the Skin.—*The British Journal of Dermatology* for September and October, 1910.

Dental News.

The second Annual Dinner of Guy's Zahnleiste was held on October 8th at the Trocadero, the President, Mr. S. Wilson Charles, in the chair. There were present as guests of the Zahnleiste Messrs. M. F. Hopson, E. B. Dowsett, F. J. Pearce, H. C. Malleson, H. P. Aubrey, and H. Chapman.

During the evening Messrs. P. S. Humm and W. S. Lakeman sang very well, and the hair of all present alternately rose and fell as Mr. W. A. Hodgson played on their emotions with his recitations.

Although no speeches were to be allowed, an exception was made in the case of Mr. MacDonald Watson, who put forward a very interesting and attractive proposition for demonstrating to the public the value of conservative dentistry.

Mr. M. F. Hopson, also, in lieu of a speech, related some delightful little anecdotes which pleased everyone. There was only one drawback—he didn't relate enough.

Mr. D. B. Tasker was elected President for the forthcoming year, and Mr. F. Bocquet Bull was re-elected Secretary.

Messrs. T. Lemâle & Co., late of Poland Street, have, owing to the increasing demands of their business, taken extensive premises at 51, Great Marlborough Street, W. These are a very fine range of show-rooms and offices fitted up in a very superior manner, splendidly lighted, and ideal for the display of stock. Messrs. Lemâle are one of the oldest firms in the Dental business. Their specialities are well known and much in request. The firm stock every Dental requisite known, at prices which will appeal to most. The operations of the firm are, we understand, very extensive throughout the country. They invite members of the profession, students and others interested to view their new and varied stock.

Pass List.

Final Conjoint Examination, October, 1910.

Medicine and Surgery.—A. H. Gool, A. H. Todd, *A. D. Vasquez.

Medicine and Midwifery.—J. A. Delmege, *G. T. Mullally.

Surgery and Midwifery.—E. Billing.

Medicine only.—A. M. Bodkin, L. C. D. Irvine, *R. Montgomery, *H. F. Renton.

Surgery only.—*G. B. Cockrem, G. R. Hind, *W. H. Talfourd Jones, *C. D. Killpack, *W. Reynolds, *Q. H. Richardson.

Midwifery only.—H. G. B. Blackman, B. Blackwood, G. Alan Blake, N. S. Carruthers, *A. Neville Cox, F. N. Doubleday, W. T. Chaning Pearce, B. T. Verver, M. C. Wall, O. E. Williams.

*Denotes completion of examination.

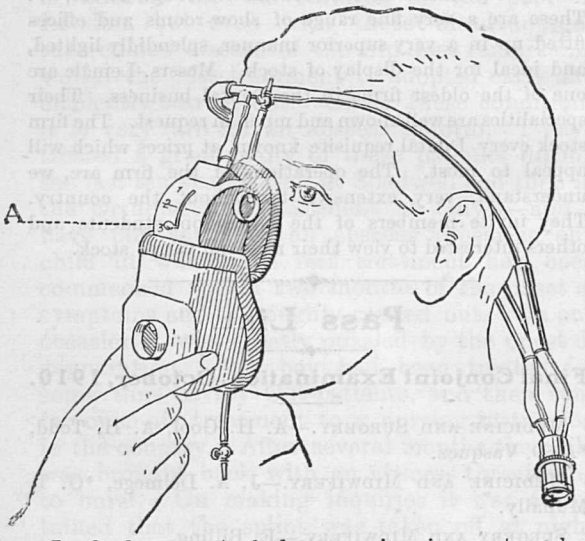
A New Method of Administering Nitrous Oxide, with or without Oxygen, for Prolonged Dental Operations.

The Apparatus used is shown in the accompanying woodcut, and consists of the following parts :—

A special form of inhaler, which I call a *Naso-Oral Inhaler*, and which has two parts—a nose-piece and a mouthpiece. A metal attachment is adjusted so that two rubber tubes are in connection with the ordinary "gas bag." These tubes pass one each side of the patient's head, and are joined to a hollow metal T-piece, which rests against the forehead. The vertical or lower part of the T-piece has a wider bore, and is joined to the top of the nose-piece by a short piece of rubber tubing.

The Nose-piece is so made that it takes up the minimum amount of room (so as not to get in the way of the operator), and at the same time has the maximum width for its apertures. Running down the centre is a sliding plate (the regulator), which can be adjusted to the following positions, so that—

1. The supply of gas is immediately cut off, and air simultaneously admitted.
2. Gas is admitted only to the nose.
3. Gas is admitted to the nose and mouth (as shown in the illustration).



In the lower part of the nose-piece is a rectangular opening, which serves two purposes—

(i.) Admits air, *provided that the mouth-piece is removed, and the regulator is in Position 1.*

(ii.) Communicates with mouth, for the passage of gas, *when the mouthpiece is in place, and the regulator at Position 3* (*vide* illustration).

An expiratory valve is on either side of nose-piece. Nose-pieces can be obtained fitted with or without pneumatic rubber cushions, though the former is advised, thus ensuring a better fit round the bridge of the nose.

Coming off from the smooth facet of metal, just in front of the nitrous-oxide tube, but not shown in the woodcut, is a short metal tube for the oxygen attachment. This tube is closed at its upper end by means of a metal cap, to prevent the escape of nitrous oxide when the oxygen attachment is not in use.

The Mouthpiece needs no special description other than the illustration. It is supplied with an expiratory valve in the centre, and a pneumatic rubber pad or cushion round its sides. The rubber pad is essential in the case of the mouthpiece. Both the rubber pads can be easily removed for sterilizing purposes.

I.—WHEN USED FOR THE ADMINISTRATION OF NITROUS OXIDE *WITHOUT* OXYGEN.

The connections having been made, as already described, the gas bag filled, and the patient ready with mouth-prop in position, the nose-piece is adjusted with the regulator at I., *i.e.*, the patient is breathing only air through the nose-piece.

(*a*) In the Case of Normal Patients.—A few words of encouragement and instruction should be given the patient as to breathing through the nose. After a few inspirations of air, when he should have become accustomed to the inhaler, and when he is seen to be breathing normally, the valves on the stopcock of the gas bag are thrown out of action (as they are unnecessary, there being valves on the nose-piece), and the regulator is then turned to 2. At this point the mouthpiece is put in position, which is, so that its upper border lies between the lowest part of the slot in which the regulator slides, and the upper border of the rectangular opening, which admits air. It is important that a gentle but constant pressure be exerted on the bag, to force the gas through the tubes, otherwise the patient is apt to strain on inspiring, and hence suffer from feelings of faintness on recovering from the effects of the gas.

There are several forms of bag-compressors on the market, all more or less after the same principle. One that I have found work admirably, is the steel-spring compressor that was designed by Mr. Trewby, house-anæsthetist at the Royal Dental Hospital of London, and used by him at that hospital.

A more scientific and preferable method, however, is to use a special form of gas regulator, which can be joined to the gas cylinder, and which obviates the necessity of using a gas bag. Connected to both cylinder and gas regulator are nine coils of thick copper wire, beneath which is a small metal stand, on which rests an ordinary spirit lamp. This little lamp, when lighted, heats the copper wire, two or three minutes only being necessary to produce gas at body heat, provided an average pressure is exerted. Fixed to the top of this gas regulator is a fine screw adjustment, by means of which *any* desired pressure can be obtained.

If this regulator is used, the gas bottles will be found not to freeze, as is often the case if a great number of gas patients are treated in sequence.

Usually in from forty-five seconds to a minute the mouthpiece can be removed, and the dental operation started. There is no need to "push the anæsthesia" to the end of the third stage, as is done with the ordinary face-piece, but the operation can be proceeded with at the *beginning* of the third stage of nitrous oxide narcosis.

Best Signs indicating the Stage in the Administration at which to Remove Mouthpiece.—

(i.) Eyes become dull and expressionless, but conjunctival reflex persists.
(ii.) The pupils begin to dilate.
(iii.) Strabismus sometimes occurs.
(iv.) Limbs become flaccid.

While the dental operation is proceeding, anæsthesia is kept up, until the breathing loses its rhythm and a slight stertor is audible, together with other approaching signs of deep nitrous oxide anæsthesia. These signs generally occur within thirty seconds of the removal of the mouthpiece, and at this point two full inspirations of air should be allowed, or the patient should be permitted to breathe air for about five seconds. When these deeper signs again appear, the patient can have, as a rule, from five to twenty seconds for breathing air, *i.e.*, from two to eight inspirations, when the gas should again be turned on by the regulator on nose-piece.

The administrator should endeavour to steer clear of deeper nitrous oxide narcosis, and should avoid such signs of deep anæsthesia as "oscillation of the eyeballs," and "jactitations" (clonic muscular movements of the thoracic and abdominal muscles and extremities, and spasmodic elevations of the larynx towards the epiglottis and base of the tongue, the last mentioned giving rise to the stertor).

I find it better to begin the administration of gas through the nose only, as it is easier for the patient to continue breathing so, after the removal of the mouthpiece. The mouthpiece could be discarded in normal cases, the patient's mouth being closed at the beginning of the administration, which is conducted by means of the nose-piece alone. When the patient is sufficiently under, his mouth could be opened up with a Mason's Gag.

(*b*) In the Case of Alcoholic Patients and Mouth-breathers, &c.—The administration is proceeded with on similar lines as before, with the exception that when the patient has inspired one or two breaths of air through the nose-piece, and has become used to the inhaler, the mouthpiece is adjusted *immediately*, and the regulator moved to Position 3 (as depicted in the illustration), *i.e.*, the inhaler is practically converted into an ordinary face-piece. The patient is now having gas administered to him through the nose and mouth. This is kept up until the patient is ready for the operation, when the regulator is moved to Position 2, and the mouthpiece withdrawn.

This method is desirable with powerful men, or alcoholic and other excitable patients, as the period of induction is considerably lessened. Mouth-breathers are certainly not very good patients as regards nasal administration, but, even they can be made to have a longer period of anæsthesia, than they would have with the ordinary face-piece method.

II.—WHEN USED FOR THE ADMINISTRATION OF NITROUS OXIDE *WITH* OXYGEN.

As already explained, there is a short metal tube of narrow bore at top of nose-piece as a fixture, to which another tube of similar bore can be adjusted. This latter tube is the oxygen attachment, and has fixed to it an ordinary long-arm tap for regulating the supply of oxygen. This tap can be made to pass across an arc plate, which has a series of depressions into which a stud spring catches. The depressions are placed very close together, so as to give the smallest variation to the arm, at the same time holding it securely during any of the movements. When the arm, or tap, is vertical it is full on, and when horizontal the oxygen is turned off.

A rubber tube of equal bore is joined to the other end of this metal tube, and communicates with the oxygen bag, which should have a capacity of about one and a half gallons. The nitrous oxide and oxygen bags are both filled and hung on a stand or on to a metal bar, which can be adjusted to any operating chair. The bags should hang immediately to the left of patient (out of the operator's way), and in such a position that they can easily be seen by the anæsthetist. They should also be as near to the patient's head as possible, so that the minimum distance from gas bags to nose-piece can be obtained.

If a pressure regulator for the N_2O is used, only one bag with a spring compressor will be needed, viz., that for the oxygen.

The N_2O and the oxygen must of course be administered under an equal pressure.

The oxygen is used simply to control the number of respirations, and keep down the cyanosis.

Usually in about forty-five seconds the breathing becomes slightly laboured and noisy. At this point oxygen is gradually admitted, when the breathing will generally quieten down. If excitement ensues the supply of oxygen is lessened or turned off altogether, and two or three inspirations of nitrous oxide allowed. After this the oxygen can be turned on again very gradually.

In this manner the respirations can be controlled. Air, however, should be admitted from time to time.

Signs to watch for to indicate the best time for removal of mouthpiece:—

(i.) *Respiration* is regular and tranquil, or is softly snoring in character (similar to the breathing in a good chloroform anæsthesia).
(ii.) *The conjunctival reflex* is abolished.
(iii.) *The eye-balls* are fixed and widely staring, or present slight oscillatory movements.
(iv.) *Extremities* are flaccid (or, in rare cases, very rigid).

Sometimes the conjunctival reflex is still present, when the other signs appear, in which case the mouthpiece can safely be withdrawn and the operation started.

The other particulars are essentially the same as in the administration of nitrous oxide alone.

This method should be used in cases of disease in the circulatory system, heart weakness, &c.

ADVANTAGES OF THE METHOD.

I.—Its Advantage over the usual Method of Administering Nitrous Oxide and Oxygen, or Nitrous Oxide alone.

1. A much longer anæsthesia is obtained.

Mr. J. H. Patterson, by means of the nasal method of administration, maintained anæsthesia for nine minutes fifty-five seconds, using nitrous oxide without oxygen. This was at a public demonstration at Cambridge, on a man aged 35. The patient was kept absolutely quiet, and recovered after a very few minutes. During anæsthesia two exposed and inflamed pulps were removed, and the two teeth partly prepared for crowning. In addition to this, eighteen teeth were extracted. On twenty-three occasions the anæsthesia has exceeded four minutes, but it must be mentioned that these times represent the actual duration of the operation, and not the total available anæsthesia, which would be twenty or thirty seconds longer, and which could have been further prolonged had the operation required it.

2. There is no necessity to "push the anæsthetic" at all, as is often done to an asphixial point in the ordinary face-piece method, in order to obtain a longer anæsthesia. Many hold the view that this "pushing the anæsthetic" is unscientific and wrong in principle, though one need not doubt for a minute that it is perfectly safe in the hands of an expert anæsthetist.

3. *The operator* would appreciate this method, as it gives him longer time to do the work in hand thoroughly. Each extraction being performed deliberately, would be a great advantage to—

4. *The patient*, inasmuch that it would mean less damage to the alveolar process, and thus a quicker healing and absorption of the tooth sockets.

5. The instantaneous action of the oxygen in arresting accelerated breathing.

II.—Its Advantage over Ether, Ethyl Chloride, and Chloroform.

1. It is a safer anæsthetic.

2. It requires no special preparation of the patient.

3. The patient's recovery is much quicker, and is, as a rule, unattended by any unpleasant after-effects, as vomiting, headache, &c., the patient being quite able to go home after a few minutes.

ADVANTAGES OF THE APPARATUS.

1. The extreme simplicity and ease in learning how to manage it. The anæsthetist practically has the whole control of the inhaler and the patient, in the small handle of the regulator.

2. There is no need to remove the nose-piece from the patient's face to admit air, this being a great advantage to the operator. Its shape, also, is such that it is well out of the operator's way.

3. The Naso-Oral Inhaler will fit practically everybody.

4. The nose-piece is so made that it takes up the minimum amount of space, and at the same time has the maximum size for its apertures.

5. The oxygen is quite independent of the N_2O.

6. The quantity of oxygen used is always visible.

7. Great economy of oxygen.

8. Great economy of N_2O if a regulator is used.

9. Both nose-piece and mouthpiece are supplied with expiratory valves.

10. The apparatus can easily be adjusted to any gas bag, gasometer, regulator, or stop-cock, that the dental surgeon may already have in his possession.

This apparatus has had a successful trial at the Dental Out-patients' Department during the summer term and long vacation, and has been approved by the dental surgeons and anæsthetists present.

The following can be cited as an example of one of the cases:—

Last Saturday morning (October 22nd), Mr. Marmaduke Page easily maintained anæsthesia with this apparatus for a period of about seven or eight minutes, though, unfortunately, no exact time was recorded. During anæsthesia, Mr. Montagu Hopson extracted an upper right central, and removed a myeloid epulis, scraping both sides of the alveolar process thoroughly. The socket was then cauterized with pure carbolic acid, and the central replanted, being kept in place by a special dental splint, made of metal, which was cemented over the teeth with copper oxy-phosphate. The splint was held firmly in position while the cement set, anæsthesia being maintained during the whole process.

Emily G., the patient (girl, æt. 13), had a quick recovery, with *no* unpleasant after-effects, and was able to walk home almost immediately.

I should like to acknowledge, that the appearance of this apparatus is largely due to the excellent instruction and practice that I was fortunate enough in obtaining from the Staff Anæsthetist who taught me. If, by chance, he should read this article, he will see that I fully appreciate the twelve months' course of instruction that he gave me, and the splendid practice I had in administering general anæsthetics as his "full clerk," in the surgical and dental Out-patients' Department.

I am grateful, also, to the dental surgeons, assistant dental surgeons, and anæsthetists, for their courtesy and kindness in allowing me to use the inhaler in the Out-patients' Department.

Acknowledgments are due to the Dental Manufacturing Company for their willingness in making the apparatus for me, for their help in assisting me in getting out a universal shaped nose-piece, and for their patience in making many slight alterations to perfect same.

In conclusion, I wish to thank Mr. Kenneth Hoby, L.D.S. Eng., and Mr. Ellison, co-manager of the D.M.C., for help as regards the drawings and woodcut.

NORMAN S. HEEGAARD WARNER.

The Naso-Oral Inhaler, together with the gas regulator and bag compressors mentioned in this article, can be obtained from any surgical or dental depôt, or direct from the sole makers, the Dental Manufacturing Company, 6–10, Lexington Street, Soho, London, W.

Rugby Football Club Ball.

The above Ball, postponed from June 20th owing to the death of the late King, was held at the Galleries, Prince's Restaurant, Piccadilly, on Monday, October 24th. This is the first ball given by the club, but the success of the evening leads one to hope that it will be regularly repeated in future years. Mrs. Frederick Taylor, who kindly acted as hostess, received the guests, her position being particularly appropriate on this occasion, since Dr. Taylor has been President of the Rugby Club for several years, and has always taken great interest in its welfare.

That the Ball would be a success was evident from the very beginning, the band and the floor being excellent, and the dancers showing their appreciation by encoring every dance from the second onwards. This was, perhaps, a mistake, since it tended to shorten the second half of the programme, always the more enjoyable of the two.

The supper arrangements were well carried out, and here a word of praise must be given to Mr. Vicary for kindly drawing the clever and artistic design which adorned the menu cards.

The second half of the evening, as is usual on such occasions, went with an even better swing than the first, partly due to a slight thinning in the number of dancers, which before supper had been rather greater than the room would comfortably hold.

The President of the Hospital, Mr. Cosmo Bonsor, and Mrs. Bonsor, and the Treasurer, Lord Goschen, were present, and amongst others (there must have been fully three hundred and fifty at the beginning of the evening) were :—Dr. and Mrs. Frederick Taylor, Lady Perry, The Matron, Dr. and Mrs. Pitt, Mr. and Mrs. Symonds, Dr. and Mrs. Fawcett, Mr. and Mrs. Steward, Mr. and Mrs. Fagge, Mr. and Mrs. Rowlands, Mr. and Mrs. Turner, Dr. and the Hon. Mrs. Eason, Mr. and Mrs. Ormond, Mr. and Mrs. Thompson, Mr. and Mrs. Mollison, Dr. and Mrs. Shenton, Mr. and Mrs. Davies-Colley, Mr. and Mrs. Hughes, Dr. and Mrs. Cameron, Drs. Hertz, Stevens and Rippmann, and Messrs. Pollitt, Townrow and Aubrey.

From the Gazette's Special Pathologist.

All specimens—particularly those of solid tissues—should be accompanied, if possible, by a short clinical and post-mortem history, and a postal order for 2s. 6d. An extra charge of 6d. per slide is made when prepared sections are to be forwarded.

H. J. H., Amersham.—Blood serum, inoculated with this swab, gave after incubation a culture containing rod-shaped organisms and torulæ, but no Klebs-Loffler bacilli were found.

PATHOLOGIST.

Sport.

Rugby Football.

GUY'S v. CATFORD BRIDGE.

This time-honoured match was played at Bellingham on Saturday, October 8th, on very hard ground. The result was a draw of 3 points all, not a very satisfactory result to either side, but, on the whole, a fair index of the day's play.

The Guy's forwards commenced slackly, and this gave the opposing pack, a useful lot, who always managed to do their best against the hospital, an opportunity of getting into full swing at once. They rushed the ball into Guy's "25," and it was some time before Hind got his men shaken down; they were kept too busy defending. At length the pressure was eased and play taken to mid-field. A scrum or two ensued, and from one Larmour, who played as a wing forward, kicked hard towards the Guy's goal line; following up quickly, he kicked on over and touched down before Lacey reached him. F. Helder missed the kick, and just afterwards missed a penalty almost in front of goal—a lucky escape for Guy's. The hospital forwards were now playing much better, but one of them kicked too hard and enabled Catford to clear well back; luckily, Stringer saved the ball from touch, and with a finely-judged kick found touch by the corner flag. After loose play the ball bounced towards Stringer, who promptly sent across to Clark, who kicked ahead, and Flooks, following up, scored a try. Hind made an admirable attempt at goal, but just missed the post.

The second half was more open, but neither inside threequarters let the ball away to his wingman sufficiently, and, again, the Catford forwards broke up smartly and spread across very rapidly, so that the passing three-quarter game was a difficult one to carry out successfully. Twice Hind had shots from penalties, but the places were awkward; both attempts were very near, as was a left foot drop at goal on the part of Stringer. The game was very fast just before the end, both sets of forwards dribbling to either end in determined fashion; but the defence of the backs was very sound, Stivens and Lacey both playing with the utmost coolness and resolution, keeping their respective lines intact until the long whistle announced "no side." Team :—

Guy's.—G. E. W. Lacey (back); L. B. Stringer, W. E. S. Digby, W. T. Clarke, T. Flooks (three-quarters); C. B. Pritchard, C. H. Medlock, (halves); G. R. Hind, R. S. Kennedy, H. Hoby, V. Glendining, T. D. M. Stout, A. B. Danby, M. Tweed, A. W. A. Davies, (forwards).

Remarks.—The forwards played well after the first twenty minutes. Kennedy ably assisted Hind in leading the pack, and was most conspicuous throughout. Tweed kicks a little too hard; Davies played a good bustling game; one or two others were short of training, and will do better when more fit. Pritchard and Medlock were

not a very happy combination. The latter takes his passes admirably, but does not yet give them with his usual snap and smartness. Stringer and Flooks did all that came their way. Neither inside threequarter passed quickly enough; the attacking movements were too slow. Lacey played an excellent game.

GUY'S v. ROSSLYN PARK.

Played on the Old Deer Park on Saturday, and resulting very differently to what has been generally the Hospital's fortune on this ground. The final total was a score of 41 points to 4. This total was made up of five placed goals, one dropped goal, and four tries, to one dropped goal. Rosslyn Park were by no means at full strength, so too much must not be made of the hollow victory, but for all that the Hospital men were in good form, and without being unduly egotistic it is safe to say that they would have put up a good game against most sides.

The forwards commenced by taking matters much their own way, and but very little time had elapsed before Stranack got over with a couple of tries, admirably led up to by the good work of the pack generally. Medlock was successful with both kicks. The Park backs, Monaghan and Dixon, more especially, tried hard to keep the scoring down, but Guy's were out for points, and evidently satisfied that daring methods paid the best, they sacrificed everything to attack, in doing which "handball" was as much in evidence by the forwards as by the backs. The end justified the means, but one doubted if it was the best practice for the hard and important matches of the future. Before half-time Flooks, Medlock and Stokes added tries, one of which Medlock converted. Lacey also dropped a goal, but a reply came from Rosslyn Park in the shape of a dropped goal by Hiley. At half-time the score was, Guy's 25 points to Rosslyn Park, 4.

After half-time the Park side were rather better, but it must be confessed that they never really looked like levelling up the game or, in fact, like reducing the points. For a time the scoring was kept down, but the Hospital pack was in great form, and Stranack recommenced the scoring, to be followed by other tries gained by Flooks, Medlock and Stringer. The place kicks were taken by Medlock, who was successful with two of them, bringing up the score to 41 points to 4, or 6 goals (one dropped) and four tries to one dropped goal. Team:—

Guy's.—G. E. W. Lacey (back); A. L. Stokes, L. B. Stringer, W. E. S. Digby, T. Flooks (threequarters); G. B. Pritchard, C. H. Medlock (halves); G. R. Hind, W. S. Stranack, R. S. Kennedy, H. Hoby, T. D. Stout, M. Tweed, O. G. Parry-Jones, A. W. A. Davies (forwards).

Remarks.—The game was too one-sided to really extend the Hospital XV., so that it will be better to postpone criticism to some future occasion.

GUY'S v. U.C.S. OLD BOYS.

The U.C.S. Old Boys are not the strong side of a few years since, and more especially recently they have fallen on dull times. Their previous matches this season have proved them to be weak, so it was not surprising to find they had to submit to a somewhat heavy defeat—56 points to nil. The Hospital were again in excellent fettle, but two matches in succession in which they have been able to do pretty much as they liked is not the best sort of practice. On the other hand, it was as well, in view of meeting Cambridge on Wednesday the 26th inst., to have an easy match.

The scoring was opened by Moberly, who followed up persistently, and was rewarded by being favoured by the bounce of the ball. His try was not converted by Stokes, neither did the same player add to the second try scored by himself. Davies gained the third try, Hind failing at the attempt to goal. Some very fine passing, and Stringer sent Stokes over. This time Stokes kicked a goal. Stranack was the next to score, and before half-time the three-quarters pressed well for Stokes, the last to receive, to score a sixth try. Neither of the last two were converted, so that Guy's changed ends with the very useful lead of 20 points.

The defence of the Old Boys broke down completely in the second half, only Griffith-Jones putting up anything like a good defensive game. Jones is to be congratulated on a good and plucky display under circumstances which any player would recognise as most discouraging. Stringer got to work speedily, and twice in quick succession crossed the line. His tries were goaled by Hind and Glendining respectively. Digby put on a nice dropped goal. Fine passing, and Stringer and Stokes were away; they quite beat the opposition by their in-and-out passing, the actual try being gained by Stokes. Digby goaled. Flooks, Stringer and Stokes were instrumental in gaining the next point, a strong run from half-way, where Stringer received from Flooks, and handed judiciously inside to Stokes, who got right round behind the posts for Glendining to convert. Before the end, Flooks scored twice and Davies twice. Moberly, Hind, Kennedy and Stokes took the kicks in the order named, but none were successful. The final total reads: Guy's, 5 goals (1 dropped) 9 tries to nil. Team:—

Guy's.—G. E. W. Lacey (back); A. L. Stokes, L. B. Stringer, W. E. S. Digby, T. Flooks (halves); J. G. Saner, C. H. Medlock (threequarters); G. R. Hind, A. V. Moberly, W. S. Stranack, R. S. Kennedy, A. W. A. Davies, M. Tweed, T. D. Stout, V. Glendining (forwards).

Remarks.—The forwards played well. There was a tendency on the part of at least three to "wing," but maybe the lack of opposition condones this; we trust it will not develop into a habit. With Hind in the front row it was only to be expected that Guy's should get the ball. On one or two occasions one caught glimpses of some good "screwing." Bearing in mind to what good purpose Cambridge used this tactic last year, and the speed of some of our pack, it would not come amiss if it were made more use of. In the loose Kennedy, Moberly Stranack, and Davies showed to advantage. Tweed promises to be a welcome addition to the pack. The

"footwork" of Kennedy, Moberly, and Stranack was excellent. Behind the scrum Saner showed to advantage, getting the ball away well; Medlock showed a distinct improvement in "getting rid of it," but still he has not that faculty of passing at the right moment; he must learn to run straighter. Stokes on the wing delighted the onlookers by doing what his critics have always begged him to, to wit, fending well and running with more determination. Particularly pretty was the try of his, scored after crossing inside to Stringer, and so avoiding being crowded out. Stringer as a centre could be improved upon, as a wing he is almost irreproachable. Digby still shows a tendency to hang on. His dropped goal was very useful. Flooks had little to do and did it well. He showed a great knowledge of the game, and though light, would, we venture to state, make an excellent centre. Lacey was not troubled much, and discharged the little he had to do well.

GUY'S v. CAMBRIDGE UNIVERSITY.

This fixture was to some extent robbed of its interest by McCosh and Ovens, the two Varsity freshmen, not turning up. Substitutes were found in Glendining and Monaghan. Unfortunately, before half-time Monaghan was concussed, and Pyman, the old Blue, who was a spectator, was, with the permission of the Guy's skipper, allowed to play in his place. At half-time Guy's lost Pritchard with a broken thumb, so that it may fairly be said the hospital won on their merits, as from now till the end they played with only fourteen men, Hoby coming into the threequarter line and seven men remaining in the pack.

Soon after the game commenced Guy's started passing, and eventually Stokes, running in determined style, crossed for a try. Taking the kick himself, no addition resulted. The Cambridge forwards were very well together and worked back, keeping Guy's near their own "25." Here off-side against the hospital enabled Lockhart to land a fine penalty goal from the touch-line. Marburg and later Stringer put in some good kicks, the play eventually settling near the Varsity goal line, where Medlock, securing from Saner, feinted, and scored beneath the posts. A goal was kicked by the same player. After this, Monaghan was led from the field, and Pyman took his place. The next outstanding item was a great dribble by Stranack, backed up by Kennedy, ending in touch with Guy's well placed. A scrum, and Hoby falling over with a try, which Hind missed goaling, brought the points up to 11 to 3 in Guy's favour, changing just after to 11 to 6, as Lockhart, from long range, kicked a goal from a mark.

Half-time was now taken, and Pritchard retired with his damaged thumb. A fine combined run, which should have been nipped in the bud at the outset, Hind failing to tackle the man with the ball, saw the Cambridge men pass and inter-pass the length of the field, Fraser eventually getting the try which Lockhart easily goaled, thus bringing the scores level. From this point to the end Guy's played better and better. Jones brought all his personality to bear, and with the forwards ably led by Hind victory was well within grasp. Stokes put his side ahead with a grand penalty goal, and next good work sent Stringer over with a try which Stokes goaled. After this, Stranack followed up a high punt by Jones and sent out a rattling pass to Medlock, who scored a fine try. Then with Jones sending an express pass to Stringer, after he had eluded several opponents, Stringer's tremendous pace did the rest, a try resulting. Neither of the last two tries were improved on, and the final total was: Guy's, 2 goals, 1 penalty goal, 4 tries (25 points); Cambridge, 1 goal, 1 penalty goal, 1 goal from a mark (11 points). Teams:—

Guys.—G. E. W. Lacey (back); L. B. Stringer, G. B. Pritchard, J. P. Jones, A. L. Stokes (threequarters); J. G. Saner, C. H. Medlock (halves); G. R. Hind (Capt.), A. V. Moberly, W. S. Stranack, R. S. Kennedy, H. Hoby, T. D. Stout, A. W. A. Davies, M. Tweed (forwards).

Cambridge University.—A. C. Green (Caius) (back); V. H. M. Coates, Caius, J. A. Schofield (Caius), F. C. Pyman, C. L. Marburg (Pembroke) (threequarters); J. H. B. Lockhart (Jesus), B. S. Cumberledge (Emmanuel) (halves); R. Fraser (Capt.) (Pembroke), A. F. Botham, Clare, A. E. Kitching (Jesus), F. T. Mann (Pembroke), J. G. Greenwood (Kings), C. K. James (Caius), B. T. C. Fawyer (Pembroke), V. Glendining (forwards).

Referee.—Mr. E. F. Walker.

Remarks.—The Guy's pack played a splendid game, and to see them, seven men only during the second half, not only holding, but shoving the Cambridge forwards, was a sight that filled their supporters with delight. Hind, Stranack and Kennedy in particular played an excellent game, Hind's tackling, and Stranack's loose work being worthy of the best hospital traditions. Indeed, the only fault in the forwards' play was a tendency not to mark their men closely enough from touch, a fact which gave the Cambridge backs several openings. At half, Saner, although at times a little slow in getting the ball away, had his man well in hand, while Medlock's kicking and following up were a feature of the game. He has, however, a tendency to stick to the ball much too long before passing. At threequarters Pritchard was playing in a new position, and since he had to retire at half-time criticism is difficult. J. P. Jones was in characteristic form, and gave some delightful exhibitions of scientific dodging and sound tackling. Stringer, although hurt early in the game, ran as straight and strongly as ever, while Stokes, as regards place-kicking, following up, and running straight was all that could be wished. He still, however, lets himself be tackled rather cheaply where a hand-off with his weight behind it might easily get him through. Lacey at back was not quite at his best, although his display was as plucky as ever. Cambridge were not at full strength, it is true, but still the result of the game is one on which we may well congratulate the fifteen.

Association Football.

GUY'S v. CROUCH END VAMPIRES.

This match was played at Honor Oak Park on Saturday, October 22nd, in fine weather and with the ground in good condition. Guy's, who were without Neely, won the toss, and decided to kick towards the pavilion.

Within two minutes of the start the forwards took the ball down the field, and as the result of some very effective combination Berg was placed in a good position and scored with a good shot. This early scoring put our visitors on their mettle, and they were soon causing our defence some trouble, and Rook, in goal, had to save on several occasions. Guy's forwards, however, were always dangerous when they got the ball, and some fine manœuvring by the inside men, particularly Birks, gave the outside men beautiful openings, and King soon put Guy's further ahead with a shot from the right wing. Play fluctuated from end to end of the field, and the opposing forwards came near to scoring on more than one occasion. But Guy's were always the better team, and were 4 up at half-time, Berg and Veal scoring the other two goals.

Just before the interval Kyle got badly hurt, and was of very little use for the rest of the game. This was rather a handicap, and our opponents scored 2 goals in quick succession within five minutes of the resumption of play, one of the goals being headed in from a corner. Guy's were soon worrying the opposing defence, however, and further goals were quickly scored by Veal and Berg, the former's goal being the result of a particularly fine piece of play. Our opponents now took up the attack and forced a corner, but made little use of it, and shortly before the end Birks scored a wonderful goal from a very awkward angle. Result: Guy's, 7; Crouch End Vampires, 2. Team:—

Guy's.—H. C. Rook (goal); J. T. Keer, C. E. Rice (backs); A. F. Camp, J. Kyle, C. D. Neale (half-backs); R. M. King, V. E. D. Berg, R. M. Veal, A. H. Birks, S. W. Bevis (forwards).

Remarks.—The forwards were really splendid, and the complete understanding between them at times almost bewildered the opposing defence. Veal proved a great acquisition, not only in his midfield play but also in his ability to shoot hard and accurately. Birks was very clever, as was also Berg, and King's pace enabled him to beat his man on almost every occasion and put in some fine centres. The fact that the forwards were so effective resulted in the halves and backs having a less strenuous time than usual, and except for short periods, notably just after half-time, were able to hold the opposing forwards in check and keep the ball well up the field. The shots by which our opponents scored gave Rook no chance, and he was very safe with any other shots that came his way.

Appointments.

Civil.

Thomson, C. B., F.R.C.S. Eng., L.R.C.P. Lond., has been appointed Certifying Surgeon under the Factory and Workshop Act for the Wimborne District of the County of Dorset.

Naval.

Fleet Surgeon F. Davidson Lumley, R.N., has been appointed to the *Warrior*; Staff Surgeon M. P. Jones, R.N., to the *Hogue*; Surgeon F. R. Featherstone, R.N., to the *Exmouth*; Surgeon G. Nunn, R.N., to the *Shearwater*; Surgeon G. F. Syms, R.N., to Malta Hospital; and Surgeon C. G. Sprague, R.N., to the *Inflexible*.

Change of Address.

Lieutenant S. M. K. Saunders, R.A.M.C., from Royal Herbert Hospital, Woolwich, to R.A.M.C. Mess, Citadel, Cairo, Egypt.

Captain H. Watts, M.B., Indian Medical Service, from Hoshiarpur, India, to Orchard House, Orchard Road, Orpington, Kent (on leave).

Papers by Guy's Men.

A. E. Boycott, M.A., M.D. Oxon.: A Case of Unilateral Aplasia of the Kidney in a Rabbit.—*Journal of Anatomy and Physiology*, October, 1910.

Donald W. C. Hood, M.D. Cantab., F.R.C.P. Lond.: Specialism in Medicine.—*The Lancet*, 22nd October, 1910.

T. D. Lister, M.D. Lond., F.R.C.S. Eng.: Industrial Tuberculosis.—*The Lancet*, 15th October, 1910.

G. H. Savage, M.D. Lond., F.R.C.P. Lond.: Insanity and Marriage.—*British Medical Journal*, 22nd October, 1910.

W. Hale White, M.D. Lond., F.R.C.P.: The Outlook of Sufferers from Exophthalmic Goitre.—*The Quarterly Journal of Medicine*, October, 1910.

John D. Malcolm, M.B., C.M. Edin., F.R.C.S. Edin.: A Case of Carcinoma of the Cæcum removed after a Preliminary Evacuation of a Fæcal Abscess and an Ileo-Sigmoidostomy (Illustrated).—*The Lancet*, 15th October, 1910.

Birth.

DITCH.—On 24th October, at The Limes, Uckfield, to Mr. and Mrs. John R. Doren Ditch, a daughter.

Deaths.

GAMBLE.—At Barnstaple, Charles Hanlen Gamble, J.P., M.R.C.S., L.S.A., aged 85 years.

MARTYN.—On October 21st, at Bella Vista, Liskeard, Cornwall, Maud Catharine Martyn (Sister Charity, 1900 to 1905).

PENNY.—On the 23rd instant, at "Sunnyside," Teville Road, Worthing, Charles Burnidge Penny, aged 35.

Ed.—E. G. S. p.p. A. N. C.

GUY'S HOSPITAL GAZETTE.

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Passim.

CONGRATULATIONS to Mr. H. E. Perkins, who headed the list at the recent examination for admission to the Royal Naval Medical Service.

WE are asked to announce that the Annual Dinner of the Contemporaries' Club will be held on Wednesday, November 30th, at the Trocadero Restaurant, at 7.15 for 7.30. The chair will be taken by Thomas Morgan, Esq., M.R.C.S., L.R.C.P. Members intending to dine are requested to notify either of the Hon. Secs. of their intention on or before Monday, November 28th. The cost of the dinner is 10s. 6d., exclusive of wine. Hon. Secs.: E. B. Dowsett, Esq., L.D.S., M.R.C.S., 1, Gloucester Street, Portman Square, W., and Laurie McGavin, Esq., F.R.C.S., 6, Mansfield Street, Cavendish Square, W.

WE extend our sympathy to the present dressers, for the complete starvation of whom fate and authority seem to have conspired. Knowledge is no doubt an excellent food, and the surgery an excellent place to seek it, but luncheon and dinner have, to the average student, a very strong appeal. Under the present arrangements, however, the chance of his getting either at a reasonable hour appears very small indeed. It has always seemed very unfortunate that the number of dressers available should vary so, six being almost too many and two decidedly too few, and any system that would tend to make the supply more even would be very welcome to the majority of men.

A PRESENTATION of Graduates will be held at the University, South Kensington, on Monday, November 28th, at 3 p.m., when academic costume will be worn. Students desirous of attending should apply for cards of admission, not later than November 14th, to the Principal, University of London, South Kensington, S.W.

THE whole medical profession is at present looking with great interest for the results of a continued trial of the new Ehrlich-Hata "606" treatment of syphilis. That some of the results already obtained approach almost to the miraculous is undoubted, but it were well to reserve a definite opinion until time has given permanency to the cures. The danger of a hasty enthusiasm over a new remedy was too well instanced in the case of tuberculin for a repetition to be desirable, and it is only by careful and accurate recording of results obtained that the remedy can be appreciated at its proper value. The literature on the subject is already extensive, and several thousand cases have been recorded; but a number of the authors employ the superlative degree to an extent which tends to detract from the scientific value of their publications. Professor Ehrlich is to be congratulated on his caution in insisting on an extensive trial of "606" before it is placed on the market, and it rests with the profession to continue this caution, to avoid anything in the nature of over-enthusiasm, and to confine itself to an impassionate judgment on the strength of actual results obtained.

NEVERTHELESS, where prophecy is unwise, speculation is interesting, and what will happen if "606" does what its adherents hope of it, and syphilis is gradually stamped out, is a thought which opens up great possibilities. A Medicine without the myriad lesions due, directly or indirectly, to syphilis, would indeed be strange, while the effects on the race as a whole, both physically and morally, would undoubtedly be striking.

A CINEMATOGRAPH demonstration on the mechanism of phagocytosis and other bacteriological problems was recently given at St. Thomas's Hospital by Dr. Levadity, of the Pasteur Institute, Paris. The films shown were most striking, and would indicate that the cinematograph is destined to play an important part in the education of the future. The advantages of visual in addition to auditory impressions as an aid to memory are obvious, and a cinematograph would render many scientific facts, which the student finds at present only too elusive, easy of retention. We can even imagine compulsory lectures, accompanied by a cinematograph, becoming popular!

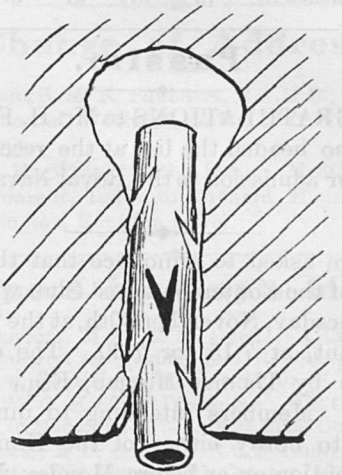
A MEETING of the Out-Patients' Tea Committee has been held, and Messrs. Kahlenberg and Saner have been appointed Hon. Secs. The entertainment given to the poor children of the Borough in the Out-Patient Department on Boxing Day is one of the most admirable of the many excellent Christmas institutions at the hospital, and deserving of every support. Subscriptions (2/6) may be sent to the Hon. Secs., and we hope to publish in our next issue a list of gentlemen who will also be ready to receive donations.

THE Secretaries of the Guy's Hospital London University Club ask us to remind men that the Dinner of the Club will be held at the Trocadero on November 24th. It is hoped that there will be a record muster, and all desirous of attending should let the Secretaries, Messrs. K. H. Digby and G. Genge-Andrews, know as soon as possible. All London men are eligible for membership, and there is no entrance fee or subscription.

Self-Retaining Drainage Tubes.

In some instances it is difficult to keep a rubber drainage tube in position. This is so where the tube has to be passed vertically upwards, as in drainage through the vaginal fornix; where there is pressure in the deeper parts of the wound, as in the case of a cerebral abscess; or where, as sometimes happens in drainage of the abdomen, movements tend to dislodge the tube.

If, however, the lateral holes in the rubber tube are cut obliquely as in the diagram, movements will only tend to push the tube more firmly on.



The principle is the same as that by which the "climbing grass" which a child puts up its sleeve will travel up forearm and arm to the neck. Where there are no movements the outwardly-directed rubber points, hitching in the sides of the wound, maintain the position. Like a barbed spear, the drainage tube can move forwards in the tissues more easily than backwards. There is, however, no difficulty in withdrawing the tube by a sharp pull with forceps. But if the tube is not inserted to the deepest part, it may, if exposed to much movement, insinuate itself further in the interval between dressings. When draining an abscess of the cheek into the mouth by this method, the buccal end of the tube, which projected half an inch when inserted, had buried itself just out of sight at the next dressing.

This method of cutting the side holes has a further advantage in that it is not so destructive to the rigidity of the tube as are the usual oval windows. Consequently the lumen of the tube is less likely to be occluded.

Mr. W. K. Fry, who has employed this method in a number of cases, points out that, by varying the obliquity of the holes, any degree of stability can be obtained. He has not noticed that the extraction of the tube, if used in suitable cases, either causes pain or requires undue violence.

K. H. DIGBY.

Faith Healing, or the Mental Factor in Disease.

A DISCUSSION on the subject took place at a meeting of the Physical Society, which was held on Wednesday, November 2nd. Mr. Neville Cox occupied the chair, and there was a large attendance of members, over 160 being present.

The discussion was opened by Dr. Craig with the following remarks:—

"The subject chosen for this evening's discussion is so large that one feels that it is almost impossible to attempt to deal with it in the time allotted for the opening remarks. Nevertheless, your Presidents are to be congratulated on their choice, as the matter is of no small importance to us as a profession unless we intend to leave to the laity the question of deciding this difficult problem. It is not my intention to-night to discuss the claims of the various sects who, each in turn, believes that it has found the key to the great secret; each bases its claims on Holy Writ, each has its chapter and verse which apparently support it, although, maybe, taken with the context, the deduction arrived at may appear to be less convincing. It is not for us, as a profession, to doubt the sincerity of their demands, but rather calmly to hear what they have to say, and finally to decide whether, after all, there may not be an underlying principle which we have either lost sight of or which we fail to appreciate at its true worth.

I will at once accept that there seems little doubt that "cures" have taken place through the instrumentality of lay persons when the medical attendant or attendants have diagnosed the case as incurable. Nevertheless, the number of such "cures" is very small when compared with the vast amount of disease, and is smaller still when allowance has been made for error of diagnosis; medical men are human, they are not infallible.

As a profession, I do not think that we attach sufficient importance to the interaction of mind upon body, and *vice versa*. There is no physical disease that has not its mental correlative. We consider one patient a good one and another a bad, such a distinction being largely based on the mental attitude of the individual. One patient believes what his medical adviser tells him, and another does not, and to account for this want of trust we must look for a defect either in the patient or in the doctor.

It is not always a question of high qualifications which makes a medical man successful in practice. Take the patient's attitude; for example, the good results of various cures for cancer in the early weeks of treatment is no doubt largely due to the hope the patient places in such treatment.

Now the feeling tones of "malaise," the fears associated with an illness, etc., may be highly exaggerated and out of all keeping to that which is justified by the circumstances in which a person may find himself, and the agitation which these fears may engender may even in time jeopardise the patient's chance of recovery. To remove them would be greatly assisting the return to health. Before going further, let me briefly point out how we arrive at a knowledge of self at any given time.

The idea of self is constantly changing as it is dependent upon the sensations, affections, feelings, ideas, and other attributes which go to make up mind at any given moment. In other words, it is sensations, special sense and organic, plus the feeling tones accompanying these sensations. But sensations tend to become associated with other sensations, and the rising into consciousness of one sensation may be instantly followed by other sensations, or ideas (which are the mental images of former sensations) which have become associated with it. For example, a nervously exhausted man may one day when at church or at a meeting have a sudden fear that he will shout out and make a disturbance, and this fear may set up a state of panic. Now the danger is that next time he goes to church, the old idea again recurs, and the feeling of panic again follows; in other words, the presence at church and the fear of creating a disturbance have become associated, and the two ideas tend to persist in association. Similarly, fears of being in a closed space, such as railway carriages. Now this association may take place in a vast number of ways, of which the following are a few examples: fears of disease or the consequence of disease, illogical doubts, introspection and concentration of attention on the physiological functions of the body, etc. Another fact that we must not lose sight of is, that unhealthy states of mind are not infrequently associated with various derangements of the functions of the body, and, further, that when such unhealthy states are corrected, the functional derangements of the body disappear. Take again, for example, fear, and observe its effect on the gastric juices, on the alimentary tract, on the respiratory system, and on the heart's action; note how it decreases muscular power, and with this decrease how it quickly awakens a sense of fatigue. This action may be sudden and of short duration, or, in the case of a phobia which has become habitual, the symptoms, although less active, are always present in a subacute form. This grouping together of associated ideas, sensations, feelings and visceral or somatic disturbances in such a way that the stimulation of one element in the group sets into activity the rest of the group, is often spoken of as a "complex." Of course, such a grouping may form a "complex" which is of advantage to the well-being of the organism, and here the complex is spoken of as a normal one, but when its action is harmful it is abnormal. The associated ideas in a

group usually appear in consciousness in a definite order; take, for example, our patient with psychasthenia; he suddenly appreciates that he is in a closed space, a sense of giddiness supervenes, rapidly followed by muscle tremor or collapse and perspiration.

Now, just as normal ideas may become associated, so also they may become "dissociated"; to this we owe the ability to forget things which are of no use to us. On the other hand, dissociation may develop abnormally, as, for example, in the explanation given by some authorities for hysterical anæsthesia. "The lost tactile sensations are only split off from the personal consciousness, and, although the patient is unaware of them, they are preserved as co-conscious perceptions or tactual ideas. To resynthesize these perceptions with the personal consciousness is to make the patient aware of them and remove the anæsthesia."

To return to *associated ideas,* as for our purpose to-night they are more instructive. We know that sensations may become associated and tend to persist in association with each other. For example, in some persons certain colours are associated with definite smells or ideas. Now, when we have in consciousness certain associated sensations or ideas, we sooner or later form a judgment concerning them, and once we have formed that judgment we tend to collect evidence supporting that judgment, and to ignore the facts which are against it, notwithstanding that the latter may be far weightier. It is in this way that many so-called delusions are formed. It is obvious that certain ideas may have become associated which are detrimental to the welfare of the organism, and the ideas may so bias the conduct of the individual that the physical health suffers, and the result is disturbances of the various systems of the body. Now, to correct the mental attitude may, and frequently does, lead to the re-establishment of the physical health.

For example, many persons, in the belief that it is harmful to them, progressively withdraw various articles of food from their diet until an insufficient amount is taken. Others, again, watch the effect of the emotions on the alimentary tract. A person who is depressed always has anorexia, whereas in happier states the appetite is good. We even see this instanced in persons who are going in for examinations, races, and the like.

Let me put the matter in another way. When we experience a disagreeable sensation we find that it tends to persist for some time after the stimulus causing it has ceased to act. We speak of this as a "memory pain," but the importance of it is too often overlooked, as it may become the nucleus around which associated ideas are grouped, and in this way form a "complex" which is physically and mentally harmful to the individual. To break up that "complex" and lay bare the original condition is one of the most certain ways of effecting recovery, and it is largely, if not entirely, through the mental faculties that we can do this. Explain to a person how the trouble originally came about, and show him step by step how the "complex" was formed, and if you succeed in convincing him, either by the clearness of your argument, or by his faith in the power at your disposal, or his belief in you as a physician, the so-called "cure" may appear almost miraculous. Every one of us who works amongst diseased humanity soon realises that many persons form habits (which are associated thought and action) during an illness which tend to invalid that person for months or years in spite of the fact that the real mischief has long ceased to act. In other words, the "memory ideas" of the former malady persist, and may become greatly augmented by the associated ideas which in time have gathered round them. The "rousing" treatment of the ignorant may cure a few, very few, and too much sympathy may invalid many, but the real hope of recovery lies in the understanding of the cause and an intelligent appreciation of how to treat it.

As I am merely opening a discussion, even if time permitted it would be improper for me to endeavour to treat this subject in an exhaustive manner, nevertheless, I feel that I shall be expected to say a few words on Psychotherapeutics. I suppose that all will agree that the underlying principle of this treatment is "suggestion." It is not my intention to discuss hypnotism further than to say that I consider that it has its place in the treatment of disease. Its scope, in my opinion, is a far more limited one than some would have us believe, but when properly employed, and in reliable hands, its value is great in re-establishing health in certain conditions. But there are other types of "suggestion." The mischief may lie in an "auto-suggestion" on the part of the patient. He may have formed a judgment, and this judgment may have become stronger by means of associated ideas.

I cannot give you a better example than the one of politics. Owing to auto-suggestion on the part of an individual, it may be impossible for a Conservative to convince a Radical that there is any good in his opinions, just as it would be for the latter to persuade the former. Again, take the auto-suggestion of suspicion which so many persons have, and notice how it colours all their thoughts and actions.

The physician may attempt, and at times with success, to analyse the "complex" which is controlling the patient, and with educated persons he may succeed in breaking it up. For example, memory pains or memory disturbances may frequently be got rid of in this way. But I must admit that this process of psycho-analysing is often a long one, and the result disappointing.

I need hardly say that it is useless to suggest to any person who is ill that it is possible by an effort of the "will" for him to cure himself. This type of treatment is by no means uncommonly adopted by the ignorant laity when the patient is suffering from

some sensory or feeling tone disorder; in other words, some subjective disturbance which has no objective symptoms.

Again, suggestion can be made by means of some powerful external agency, such as the Church, and in this way an attempt may be made to make a deep impression on the patient, and in some cases recovery may take place.

Faith healing has existed at all times, and has been carried on in a variety of forms, but most psychologists would state that the underlying principle in all these was the mental impression or suggestion, and that the supernatural powers which were invoked were merely agents to bring about this end. There are many cults in vogue at the present time. The Christian Scientist believes that God is Good and is "all reality," and he believes that disease, like sin, is evil, and therefore cannot belong to God, therefore it is unreal. In other words, he denies the existence of disease. Such a statement is too metaphysical for the true scientist; it is a belief which you must accept, but which you cannot prove.

When we turn to the Emmanuel Church Movement, here we find religious belief intermingled with psychology and medicine. It is an attempt to dualise the treatment of disease under the minister and the physician. It is claimed that the Christian Church in bygone centuries healed disease, and that for some reason the power was lost or fell into disuse. Why such a beneficent power should ever have been allowed to disappear is not explained, and is difficult to understand when we realize that there is no period in the world's history since the fall of man that disease has not existed. The essence of a religion is to teach the purpose of life and whither it is wending, and only indirectly does it deal with the body and its health; in other words, it is directive. On the other hand, the duty of the physician is to study the body and its functions, and the disorders and diseases which affect it. The priest's duty is to synthesize, and the medical man's to analyse. It would be too wide a subject for me to bring into the discussion the arguments for or against the various churches' case in their claims to heal the sick; but suffice it to say that if their curative powers are based, as they must be, on the merciful intervention of the Deity, there must be no distinction between organic and functional disease; the limit does not lie with the power, but in the faith to accept it.

Also, what if the Church has failed, and the patient has been found to lack that want of faith which it is deemed necessary to effect his recovery; what if that patient seeks medical advice, and is cured from his ill; such would seem a reward for his faithlessness—a truly paradoxical position. It is not traversing the power of the infinite or denying the existence of a Deity to say that it is impossible to treat mental changes as if they belonged to a section of their own, and were not connected with and dependent upon physical changes in the organism. Mind reflects only the symptoms of the disease; the disease is a thing apart. Mental therapy must not be divorced from physical therapy; psychotherapeutics should, in reality, be merely widening the powers of medicine. Here lies the key. The recent spread of psychological laboratories in the various Universities indicates the trend of events. Psychology is being put on a more scientific basis, and experimentation is correcting and augmenting the older metaphysical and purely theoretical formulæ. Slight abnormalities of mind which are common to all persons, may, under certain conditions, so develop by association of ideas, by forming judgments, etc., as to ultimately affect the physical health and conduct of the individual. I am here speaking of the sane. The more we understand mind the more we shall appreciate its influence over the organism, and the more we can foresee harmful developments which, by proper treatment, may be retarded or prevented. Therefore, to-night I, for one, must state I believe that mind is a factor in disease, and that it is incumbent upon all medical men to understand mental processes, and to use such knowledge as he would his understanding of the physical."

In the discussion which followed Dr. Craig's paper, Dr. BEDDARD quoted the saying that "in medicine we have to treat a patient rather than a disease," and that therefore Medicine was an art as well as a science. In private practice the art was just as necessary, perhaps more necessary, than the science. In hospital practice it was not possible to pay much attention to the mental idiosyncrasies of our patients, for the cases were mostly of acute illness, in which the mental factor was much less obvious than in the more chronic ailments. Moreover, we discharged our patients from hospital with the mental side of their illness untreated, or only partially treated.

It was obvious that mind could influence the bodily functions, and *vice versa,* so that a vicious circle was produced. It was the object of treatment to break through this circle, either on the bodily or the mental side. On the one hand, there were patients who were in a normal environment, and yet were abnormal mentally. On the other hand, there were patients, mentally normal, who were ill because they were in an abnormal environment.

Dealing with treatment, Dr. Beddard said that *direct* suggestion had largely fallen into disrepute, because it had been so much used by quacks who were not above suggesting symptoms, and then curing them by suggestion, or treating symptoms due to organic disease by suggestion. But *indirect* suggestion must enter very largely into our treatment. Many of the drugs, plasters, etc., prescribed at Out-Patients were suggestion pure and simple.

Dr. BOYCOTT claimed to know nothing about healing, and perhaps less about faith, and stated that he therefore approached the subject as an outsider.

That illness had a mental side and that mental influences might have a therapeutic effect were common knowledge. As an example, he related the history of a family who had been a thoroughly sick, ill, incompetent lot of people, suffering from a variety of functional complaints, for the relief of which they had assiduously consulted their local practitioners, and in addition had left not a few fees in Harley Street. This family came under the influence of one Colonel X., who, by methods of faith healing, cured their imaginary ailments (all save one daughter who suffered from an organic disease—acne), and converted them into a happy and contented set of people.

Dr. Boycott deprecated the sharp division of disease into the organic and functional. Without going all the way with a certain school of metaphysics and saying that the only reality is in the subjective, one might say that illness consisted in feeling ill, and not in the presence or absence of some pathological lesion. It matters nothing to a man that he is going to die at fifty or sixty, so long as he has no symptoms. On the other hand, some have symptoms and no lesion, and they are to be considered as really ill. Their feeling of illness was a reality to them. There was an enormous scope for faith healing in the world, and one must not neglect it because it had not the power of removing organic disease.

Mr. THOMPSON announced at once that he was a believer in faith healing. He suggested that there might be stepping-stones between the disease itself and the mental expression of it. The existence, for instance, of rodent ulcers and nævi over skin areas supplied by definite peripheral nerves suggested that the central nervous system might have something to do with their production. He related the case of two sisters, one of whom only had epithelioma of the larynx. According to the practitioner who told him about the case, the other sister developed the same disease within a year, simply by thinking and worrying about her sister. If, then, he argued, faith could cause disease, it should be capable of curing it. Here Mr. Thompson enlarged on the value of faith, especially in oneself, and incidentally he suggested that the reason "606" had not found favour in France was that nothing which came from over the Rhine did find favour there.

The influence of excitement in annulling pain was illustrated by the case of a footballer, who, after receiving a severe blow on the head, played the best game of his life, and afterwards remembered nothing of it.

Dr. HERTZ said that he entirely disagreed with a previous speaker who had suggested that organic disease could be caused by suggestion. In the case which had been quoted, no doubt the second epithelioma developed because there was a family tendency to that disease. While it was one of the commonest delusions of patients that they were the subject of cancer, there was no evidence that these growths or rodent ulcers or nævi had ever been caused by suggestion, or had any connection with the nervous system.

Dr. Hertz then described the group of cases where faith healing has had its greatest triumph. He defined hysteria as "an abnormal mental condition in which the bodily functions are perverted owing to autosuggestion or suggestion." It was because the symptoms were caused by suggestion in these cases that they could so often be cured by the same method. There were three chief methods of faith healing:—(1) Religious, *e.g.*, by means of miraculous waters such as those of Lourdes. (2) Christian Science. (3) Faith healing, as applied by the medical man. All three methods were in essence the same; the feature common to them was *faith*. The advantage which the medical man had over Lourdes and Christian Science was that he was able to discriminate the functional cases suitable for the treatment from the organic cases. The cases treated at Lourdes and by Christian Science included many of organic disease, which must necessarily be failures.

Dealing with the medical methods for healing by faith, Dr. Hertz said that it was usually necessary to use some accessory, such as electricity or hydrotherapeutics, which, while impressing the patient, were in reality nothing but faith healing. The Electrical Department, for instance, might well be called the Christian Science Department, especially as it contained just as much true Christianity and more science than the sect called by that name. Another veiled method of faith healing was the removal by the surgeon, generally unwittingly, of harmless organs by operation, but electricity, especially electricity with as many sparks and as much noise as possible, was by far the best method.

A very important part of the treatment was the preparation of the patient. Before treatment at Lourdes, the patients spent ten days in prayer, which assured them that they would be cured. Similarly, we ought to give the patients some preparation by persuading them of the certainty of cure. A remarkable instance was that of a girl who had had paraplegia for over a year, which had been believed to be organic. Another doctor, however, recognised it as functional, and having promised the patient cure within a month, persuaded her to send out invitations for a dance to celebrate the event, and at the end of the month she danced as well as any of them!

On the other hand, symptoms might be produced as well as cured by suggestion. If a movable kidney was found during the course of examination, it was a great mistake to tell the patient, for when she was told of it, she began to have symptoms of movable kidney from that date. There was the case related by Sir Samuel Wilks of a girl with functional paraplegia who had been assiduously treated by an old doctor as an organic case. The old man died, and the patient, as a tribute to his memory, attended the

funeral, and from that day she was cured! The moral of this was that the medical man must use faith healing and suggestion as a means of curing symptoms and not of producing them.

Mr. DIGBY said that, apart from its use in hysteria, where its value was undisputed, the only application of faith healing was as an analgesic. Even in incurable organic disease, faith healing might do good in annulling pain, but, like morphia and other analgesics, it had its dangers.

Mr. NEFT said that he had studied Christian Science and its literature very closely. The discussion seemed to be almost a glorification of Christian Science. The difference between faith healing, as applied by the medical man and by the Christian Scientist, seemed to be that the former disguised it under the form of plasters, drugs, electricity, etc., while the latter was more honest, and made no attempt to cloak it under another name. Mr. Neft went on to say that he had known many people, who had been complete wrecks, treated without success by Harley Street men, and afterwards cured by Christian Science. On the other hand, he had known also of many failures. The general public was entitled to know what was the real proportion of cases to cures, and this should be determined by some system of registration of cases treated by Christian Science. It had been shown that no London hospital could maintain its reputation for a fortnight on such a low proportion of cures as Lourdes could claim. Mr. Neft advocated a complete re-organisation of the medical profession, and the elimination of quackery both inside and outside the profession, as the cure for the present state of affairs. If this could be done, all the faith healing would be in the hands of the medical man, and it would be established on a proper basis as a method of healing.

Dr. BROOK said that in general practice perhaps 70 per cent. of the cases were neurotic. It had been well said that success in treatment depended on the amount of doctor you put in the bottle, and Professor Osler's mixture of "hope and nux vomica" had become famous. He had used suggestion in practice with great success; a case of obstinate insomnia, for example, which had been treated with every sort of hypnotic without avail, had been cured by suggestion in one sitting. In certain selected cases he had found that not mere suggestion, but actual hypnosis, must be used. Probably, in the future, definite teaching would be given to medical students in this important branch of therapeutics.

Mr. SANDISON commented on the remarkable unanimity of belief in faith healing which had been shown by all the speakers. He had tried the effect of faith healing on the District, sometimes with success, sometimes without, and he felt that what was chiefly wanted was a method of detecting the cases which would react to the treatment.

Dr. RIPPMANN gave an account of a case of hysterical fits which he had recently seen; the fits were both produced and cured by suggestion. In hospital we treated organic disease very well, or moderately well, but did not sufficiently treat the diseases of the soul. Personality was often a powerful therapeutic agent, as he showed by a case in his own experience where personality and olive oil had done wonders for a lady suffering from duodenal ulcer.

Mr. REEVE spoke of the importance in a medical training of studying other people's lives and habits. This was the reason why some men who had been studious recluses turned out very unsuccessful practitioners, while others, far less learned, who had studied their fellow-men, were often highly successful.

Dr. CRAIG, in reply, dealt with some of the points which had been raised, one by one. He thought that men should start the practice of psychotherapy in hospital; otherwise, they never would. He demurred from the idea that it was necessary to humbug patients in order to treat them by suggestion. In any case, it would be found impossible to humbug patients of the educated classes. If accessories to suggestion were used, the patient should be told their object. It was a mistake also to promise cure by a certain date.

The answer to most of the remarks that had been made about Christian Science was that it was a religion, and was, therefore, incapable of proof, and should not be compared or contrasted with medicine. As medical men, we should try to view Christian Science impartially. It contained a fundamental truth, and so did the Emmanuel movement, and other similar movements.

He had been asked to give a short way of distinguishing the type of case which would react best to faith healing. Unfortunately there was no short way. It was necessary, by talking to the patient, to show him the explanation of all his symptoms, for a symptom once explained lost half its horror. The medical student of the future would have to understand the mind as well as he now does the body.

Dr. Craig spoke of the danger of producing symptoms by suggestion. An hysterical fit, for instance, should not be suggested more than once for the purpose of diagnosis, for fear of establishing a habit.

A vote of thanks to Dr. Craig for opening the discussion, moved by Mr. Sandison, and seconded by Mr. Mutch, concluded the meeting.

PAPERS, ETC., RECEIVED. — The Polyclinic; The Prescriber; The Hospital (2); The Clinical Journal (2); St. Thomas's Hospital Gazette; The Baby's World; London Hospital Gazette; Specialism in Medicine, by D. W. Wood; Middlesex Hospital Journal; Nursing Times; St. Mary's Hospital Gazette; St. Bartholomew's Hospital Journal; S. A. Medical Journal; The Manchester University Magazine.

Obituary.

Louisa Ann Williams.

THERE has lately passed away a very gracious lady and generous benefactress of the Hospital, Miss Louisa Ann Williams.

Miss Williams first became known to us through her letter of March 17th, 1897, enquiring particulars as to the endowment of beds, and intimating her desire to perpetuate in some way the memory of her friend, Henry Pratt, M.D., sometime a student of Guy's Hospital. The reply to that letter was quickly followed by a cheque for £1,000, and the Henry Pratt Bed is now No. 29 in Astley Cooper Ward.

Miss Williams was a stranger to the Hospital; at no time was she within its gates; but the interest in the institution, originally aroused in her mind by her old friend, stimulated by the urgent appeal then being made on its behalf, thenceforth never waned.

Although an elderly lady, she maintained with the Secretary to the Treasurer a correspondence marked by the clear vision of an able and generous mind; and, some three months after her first donation, she spontaneously conveyed to the Re-endowment Fund freehold property at Leamington to the value of £3,000. This was followed at later dates by donations amounting in all to £5,000, for the endowment of five beds. These beds, bearing the simple identification "L. A. W.," will be recognised in No. 10, Barnabas; No. 4, Cornelius; No. 4, John; No. 14, Luke; and No. 1, Lydia.

Friendly communications continued to be received from Miss Williams during subsequent years, and, at her request, she was kept informed of the hospital's condition. Then, in 1906, came the climax of her beneficence, which can be best explained by the following passage from the Treasurer's Report for 1906:—

> "In addition . . . . the Re-endowment Fund received from . . . . . and from Miss Louisa Ann Williams, property and investments to the value of £16,682. Former Reports of this Hospital contain the record of many generous gifts to the Re-endowment Fund from Miss Williams, and the Governors feel that they cannot more truly express their gratitude for her latest munificence than by recording that it represented the whole of her Estate, beyond a sum sufficient for her remaining simple needs. The action of Miss Williams bears touching resemblance to that of Thomas Guy, who founded and endowed the Hospital 'in his lifetime.'"

As the final result of Miss Williams' dispositions the hospital has benefited from first to last to the extent of some £29,000, an offering entirely voluntary and unsolicited.

Miss Williams was a remarkable woman. Cultured, travelled, possessed of high powers of understanding and knowledge of the world, but, above all, simple and unselfish. But these characteristics, evident from her written word, were only realised to the full in recent years when some of us were privileged of her personal acquaintance and close confidence. Born at Maldon Rectory, Surrey, in 1821, the daughter of the Rev. Henry Williams, she survived all her relations and friends of early life, and, having lived in many places, came at last to Ross in Herefordshire, and there, near by the Hospital's estate, she spent her closing years, with a mind cheerful, serene, and unclouded almost to her death, which took place on the 10th ultimo, in the ninetieth year of her age. Her last letter, written on September 22nd to the Clerk to the Governors, says:—

> "I send you many many many thanks for the two lovely boxes of roses I have received. I am not any better, but not in a suffering condition. I hope all good things to the Hospital are prospering. This is all I can do."

Certainly Miss Williams had done what she could, and never asked even the smallest privilege in return beyond on one occasion—she was a Roman Catholic—gently expressing the desire that a crucifix might be placed somewhere in the Hospital "amongst the sick and the suffering" for their "consolation, comfort, and support;" and none will take offence at the beautiful crucifix from Oberammergau which hangs in the Mortuary Chapel. Miss Williams was laid to rest in the lovely churchyard of Ross on the 19th of October in the presence of Mr. Henry Williams and Mr. Charles H. Wells on behalf of the Hospital, and of those who had cared for her in her last illness.

If the present writer were privileged to compose an epitaph, it would be:—

> Here lies a Woman
> who in life was a
> Saint.

But Miss Williams herself supplied the words, and they are much more humble.

Guy's Hospital Debating Society.

THE first meeting of the session was held in the College Smoking-room on Saturday, October 29th. Dr. Shaw occupied the chair. The motion was as follows:—"That in the opinion of this House a system providing for the payment of Members of Parliament should be introduced."

Mr. NEFT, speaking for the proposition, said that the House, as now constituted, did not at all represent the opinion of the country. The labouring class was the largest class, and, seeing that the conditions for becoming an M.P. were that the candidate should have a sufficient income to support himself and to pay the Returning Officer's bill, the obvious result was that the majority were excluded. Forty out of the forty-five millions of our population belonged to the "workers," a term which was applicable to the professional as well as the labouring classes. The "workers" were the most important class, numerically and actually. The very life of Capital was dependent on Labour. The most important class was thus excluded from supplying the country with representatives. The injustice alone of this state of affairs was sufficient argument for the proposition. While, therefore, the manual and mental workers of the nation were refused representation, the remainder, who were the owners of unearned incomes, were allowed to make the country's laws—a function for which they were scarcely qualified. Many people, he continued, were under the impression that the House was a non-payed House at present; quite half, however, were enabled to "sit" by means of secret payment and doles from party coffers. The greatest existing democracy, he argued, should not countenance this. The alternative was for the nation to pay its own representatives. The Member of Parliament made laws which affected millions; his work was, therefore, more important than that of the ordinary citizen. We took great care to train our citizens, *i.e.*, for the professions, etc., but we never troubled to train our M.P.'s. Parliament had become a hunting-ground for the rich. This was not in accord with the dignity of governments. Summarising, he pointed out that the four essential arguments for the motion were: (1) the injustice of excluding the major class; (2) that it was against the interests of the people to be governed by a class that was not theirs; (3) that at present Parliament was not non-payed, but was wrongly paid; (4) that we could not afford to have a House of amateurs. On these grounds alone, he concluded, payment of members was an absolute necessity.

Mr. BEVAN-BROWN (opposer) considered that a change in our system of representation in accordance with the proposals included in the motion was unadvisable. Membership under the proposed conditions would, he said, become a commercial affair. The type of man who entered Parliament nowadays was that of one who had given up much to pursue the opinions he believed in. This type would be ousted by the salary-seeking type; members would no longer think for their country's good, but of how to make their positions secure. He compared the professionalism that would result to the degenerate athletic professionalism which already existed. He instanced a country where payment of members was in force, and a Government in consequence had been in power for 15 years, the members being implicitly obedient to the Government, for their own ends. The strongest argument for the proposition was, he thought, that of the injustice to the working-man. To admit this, however, your hypothesis must be that the working-man was the best representative of working-men. With this he was inclined to disagree. In America, till 1907, every Senator and Congressman drew exceptionally large salaries. In 1907 they voted themselves an increase of £500 per head per annum, and the annual bill for their payment now amounted to close on one million pounds. Parliament, he declared, should be pure and incorrupt. In conclusion, he said that the two great arguments against the motion were: (1) the fact that the system did not achieve its main object, *i.e.*, that of giving representation to the working classes; (2) that it would lead to corrupt practices.

Mr. BILLING, who seconded the proposition, considered the hon. opposer's speech to be entirely unconvincing, since he had not proved his assertion that the state of affairs in the country mentioned by him had been brought about by payment of members. Moreover, a similar state of affairs existed in the English Parliament, where all members voted in accordance with the wishes of their whips. Why, he asked, were not all arguments against payment of members equally valid against Ministers of the Crown? Why should not they be rendered grabbing and self-seeking? Finally, he stated that the sum of money necessary to pay members £500 a year would be insignificant, and would be obtained by a reduction in the expenses of an election.

Mr. GODDING, seconding the opposition, thought that if the labouring classes were represented by paid members, such members would be influenced solely by a desire to benefit their own particular trade. The spirit of self-sacrifice evinced by a member who served his country without any hope of reward would be abolished by payment of representatives.

Mr. LUCY was of opinion that men of the highest intelligence should have the largest share in the government of the country, just as a captain was more important than a private. He conceded that labour had a grievance, and thought that £300 a year would do no harm.

Mr. WICKENDEN said the whole question was a case of Plutocracy versus Democracy. At present we were governed by money which provided literature teaching men how to vote. He complained that men were still compelled to vote as their employers wished. The former speaker, he pointed out, was wrong in differentiating between captain and private, since the captain was himself a worker. He held that members ought to be paid in order that the labouring classes should have representatives of their own, since they cannot be understood except by men living under similar conditions.

Mr. PAKES demanded that we should view the question more from a legal aspect. We should constitute ourselves the jury, and consider more carefully the evidence for and against. Granting that payment of members was a good principle, as was the suggested training of members, he asked for more exactness as to the type of the system that would be adopted. He suggested that M.P.'s should take a B.A. degree in Political Economy. All the suggestions had been too vague.

Mr. WEBB complained that the Socialist element had not been frank with the House. They had applied the term "workers" to everybody; we knew that that term really applied only to the so-called lower classes. In his opinion, members of these classes were too ill-educated to be allowed a seat in Parliament.

Mr. STEPHENS said the opposition did not understand what was meant either by payment of members or by representation. All people could be divided into two classes: one consisting of those who say a country cannot govern itself; the other consisting of those who say it can. In representation, people could be divided into areas or groups. Payment of members had become more necessary since Capital came into existence, and the Capital and Labour groups arose.

Mr. RYLE strongly objected to the snobbery underlying the suggestion that had been made to the effect that the labouring classes should not be allowed representation on grounds of ill-education. Working-men were frequently extremely well educated, and just as much qualified for membership as, for instance, the brewer with an education at Eton. Criticising the opposer's arguments, he pointed out that the salaries would not be sufficiently large to attract self-seekers. In regard to the "professionalism" argument, he considered the simile most inapt. Did the hon. opposer object to doctors being paid? Finally, our present system could by no means be said to be free from corruption, and a system which could be entirely open and public would be infinitely preferable.

Mr. BERRY said that Australia offered an instance of the success of the system of payment of members. Never had that country been more prosperous and content. Further, it was impossible to suppose that the rich could understand the poor, as someone had suggested.

Mr. BARROW-CLOUGH opposed the proposition on the ground that payment of members would lower the existing ideal that members should not work for reward. He thought that the English Parliament was the finest in Europe, and that the present system should not be changed for one which had proved so disastrous in America and elsewhere. He disagreed with the statement that Parliament consisted of men living on unearned incomes; on the contrary, most members were men whose early industry had enabled them to earn a moderate income.

Mr. MILLER thought that the most successful politician to-day was the greatest liar. Socialists, he declared, advocated their cause in the hopes that they might some day govern. The bulk of the electorate were labouring men, and would soon get to consider the professional classes as the "idle rich."

Mr. PARMITER pointed out that the lower social classes were not the lower moral classes necessarily. There was a time when Parliament was spoken of as the best club in the country. Now it was the most corrupt. The rule for most members nowadays seemed to be—self first, party second, country last.

Mr. DIGBY pronounced himself in favour of the motion. Democracy, he declared, worked best. It was essential that all classes should be represented. The most intellectual were frequently not the most wealthy, and it was a pity that these should not be able to assist in the government of the country. Did the opposition object to the payment of Government officers, and did it corrupt these people? Further, if the system were introduced, labour members would no longer be responsible to a trades' union.

Mr. HANCOCK thought a little payment wouldn't hurt. His principle was, "give the working-man a chance." Working-men, he added, will always elect the man who will represent them best.

M. CHEVRAU pointed out the significance of the recent labour disturbances. He thought the labouring classes were just as capable of government as the Lords.

Mr. MULLALLY said the members of the Irish party who received payment were just as efficient as the unpaid members. As economists they were exemplary. Reports of their voting and expenditure were published periodically. One result of the present system was that we had a disproportionate number of men in Parliament who were residents in London, and drawn chiefly from the ranks of the lawyers.

Mr. BEVAN-BROWN and Mr. NEFT replied for their respective sides, and after the Chairman had briefly summed up, the voting was taken, and found to be 15—11 in favour of the proposition. The meeting concluded with a vote of thanks to Dr. Shaw for taking the chair.

The next debate will be held on Saturday, November 26th. Subject: "That in the opinion of this House the Institution of a Press Censorship is desirable." Proposer, W. Robinson; Seconder, G. Neely. Opposer, E. J. Charter; Seconder, F. Collar.

Plague in England.

Plague was first introduced into England at Weymouth in the beginning of August, 1348. It quickly spread to Bristol, Gloucester, Oxford, and so to London, where by the end of the year it prevailed in Westminster to such an extent that Parliament was prorogued. During the following year the "Black Death" raged furiously all over the country and in Ireland; it died away in the northern counties in the autumn, while its general extension over Scotland did not occur till 1350. No accurate measure of the total mortality is available. Contemporary State documents say that "the greater part of the people" died, and such information as can now be obtained substantiates this estimate. It is, for example, known from ecclesiastical records that in 1349 in Yorkshire 156 incumbents died in 236 parishes, in Nottingham 65 in 126, while of 799 parishes in the diocese of Norwich 527 were vacated in that one year. It may be presumed that the disease fell on parish priests at least as lightly as on the general population; it is, therefore, not without reason that two-thirds of all adult males are reckoned to have perished. Women probably died at much the same rate; there are, however, reasons for thinking that the mortality among children was proportionately less. The whole country was naturally much disturbed by this catastrophe. In most respects its influence has long since ceased to be felt, but the scarcity of labour in the years immediately following the great mortality put the working classes in an impregnable position, and enabled them to replace a system of decentralised tyranny by an economy based on the principles of personal freedom and liberal democracy. In the depopulated country the demand for labourers far exceeded the supply, and the lords of the manors had to leave their fields derelict or pay wages for services which they formerly exacted by rights of lordship. Whole families were wiped out, and there was at once a great redistribution of land. This sudden upheaval led also to phenomena which were in themselves not desirable. Contemporary records make particular mention of a class of sturdy beggars and idle tramps which arose, and, apparently, became a general nuisance. It would, indeed, have been strange if everyone had been content to remain quietly at work at home, enjoying the general rise in wages, and there had been no exuberant spirits who preferred to revel in their emancipation along less conventional lines. The plague killed others besides the labourers; as a consequence the professional classes—and most is known about the clergy—were recruited from uneducated persons. Their deterioration righted itself in course of time, but for many years a general depression in morals seems to have accompanied the partial fusion of the different classes. Older writers, at any rate, saw the confusion and demoralisation more clearly than the progress towards liberty.

For ten or twelve years after the Black Death, no plague in England is recorded. The second attack came in 1361, and after that for more than three hundred years it was the chief epidemic disease in the country, bursting out every now and then with exceptional severity in different places; as in London in 1499, 1563, 1593, 1603, 1625, and 1665. In each of these last three years, about one-fifth of the whole population of London was destroyed. In the great plague of 1665 in London, 97,000 died in a population of about 450,000; in the village of Eyam, with 350 inhabitants, only 90 survived, while at Colchester, 4,800 people died of plague, as against 530 from all other causes. A mortality of this order doubtless prevailed in many parts of the country of which we have no numerical record.

So anxiously were measures of prophylaxis pushed, that Tom Rogers, an Eton boy, was flogged because he—choosing perhaps the lesser evil—would not smoke tobacco in school. The notion that the great fire had anything to do with the cessation of the plague is disposed of by the fact that there were a few (2,000) deaths in London in 1666, and severe epidemics in various provincial towns, but, with the exception of a doubtful outbreak in Nottingham in 1667, this was the last of epidemic plague in England for 235 years. The disease had prevailed in Western Europe since the time of the Black Death; it disappeared generally about 1670 (though there was a famous epidemic at Marseilles in 1720), and, in the strange way that great epidemics have, it retired to the endemic foci in Mesopotamia, the Himalayas, Central Africa, and Southern China. It was from this last district that the present pandemic arose, via Hongkong, beginning in 1894. In 1896 it reached Bombay, and since then, at one time or another, has been brought to most large seaports all over the world. In Western Europe no considerable epidemic has occurred, except at Oporto. In England a small outbreak was discovered in Glasgow in August, 1901, and the infection lingered on for two or three years, but no epidemic of serious proportions resulted.

The exact investigation of many aspects of plague was possible only after the discovery of the causative bacillus by Yersin in 1894. It is now established that plague is naturally a disease of rats and that human epidemics are incidents in rat epidemics. Men do not catch plague from one another, and there are satisfactory reasons for thinking that infection is acquired from rats through the agency of rat-fleas which leave their natural hosts when these die of plague and bite human beings. Hence the liability of man to contract plague depends on the intimacy of his relations with rats. In India, just now the most active focus of the plague, the houses are ill-built and overrun with rats which live in happy domesticity with the natives. In Europe the reverse conditions prevail, and in this fact doubtless lies the chief reason why in the present pandemic the disease has altogether failed to gain a hold here as it did in the 14th century. The recent statement that there is an extensive epidemic of plague among rats and hares in Suffolk, accompanied by a few human cases, has not yet been fully confirmed. But even if the disease is genuine bubonic plague, no recurrence of the great mortalities of the past is to be anticipated. Improvements in housing, disposal of refuse and the habits of people—products, perhaps, of the Black Death—have for the most part put a barrier between men and rats which even the flea cannot easily surmount. A. E. B.

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

The Uses of Iodine.

SIR,—I have been watching, like a cat might a mouse, a correspondence in the *Journal of the Imperial British Medical Association*, on the value of iodine as a medicament.

It is most interesting to me as an old house-surgeon of Mr. Bryant to see Dr. Maylard's remarks and the letter from his old master. Maylard and myself were servants, otherwise full dressers, to Mr. Bryant, although we have not seen one another since those days. Not only can I support the remarks on the uses of iodine solutions for antiseptic purposes in your issue of October 29th, but I can add a little colouring. To the Guy's student of these latter days it may open their eyes to what they themselves may have to record in a decade or so hence on what I should like to call "fashion." Those who have read that little book, "Remedies out of fashion," will, I am sure, sympathise with these sentiments.

In the end of the seventies, Listerism and the carbolic spray were rampant with the junior surgeons of the hospital. Whispered confidences, rivalries and jealousies seemed to waft their breezes all around us, in the face of the fact that Mr. Tommy Bryant opposed the carbolic spray. He used to arrive at the entrance of the colonnade and receive that respect from his dressers as a courteous surgeon is entitled to. As he entered Job, the sister would have in readiness the basin of iodine water to wash his hands. There she would place on his right forearm a clean towel. As he proceeded in his rounds from case to case, he would look at the foot of the bed to see that the small jack-towel was fresh with iodine solution from which it was revolving from its trough of fluid below. Occasionally one might hear a "titter" at the other end of the ward from those working the hand or the steam spray. An insinuation or "Hallo," "Laudible Pus" might be cast at Mr. Bryant's dressers as they went down the passages or into the "Rooms," the House Surgeon's Quarters as they were then called. Mr. Bryant was a well-groomed surgeon, and invariably washed his hands after examining each case, as he walked his wards. He was particular, too, as to any dust about the wards, and he was a true preacher of the axiom: "Cleanliness is next to godliness."

Iodine has always been extolled in syphilis, in tuberculous disease, in parasitical affections, and particularly in dental practice. Mr. Bryant was accustomed to give five to ten minims of the tincture by the mouth, diluted accordingly, when he gave it internally. It was formerly a common remedy at Guy's in the combined product, iodide of potash, when the prescriber was at a loss for a drug. And for painting the area of a boil, irrigating wounds and protecting unbroken chilblains I am indebted to Mr. Bryant. The internal administration of the iodide of potash unmistakably causes a breaking up and an absorption of the exudative matter of a gumma. Whether it is permanently destructive to the life-history of the spirochete is doubtful. Certainly we see the transference of the disease from parents to children, even if the parents have undergone a full course of treatment with iodide and mercurial medication. And to make complete my experience of the use of iodine at Guy's, it is my privilege to mention that one of our great physicians, the late Dr. Hilton-Fagge, was in the habit of using the tincture of iodine in the post-mortem room on washed sections of amyloid liver, spleen or kidney. As a test he thought it assisted the unaided eye by picking out the amyloid matter.—I am, sir, your obedient servant, JOHN FREDK. BRISCOE.

Alton, Hants, November 8th, 1910.

THE EDITOR will, at all times, be glad to consider Articles or sketches, provided that they are accompanied by the writer's name and address, not necessarily for publication. Payment is a matter of arrangement, and the fees that the GAZETTE *can offer are merely nominal, but if the writer desires any remuneration that fact should be stated. Authors who desire reprints of their papers should make their own arrangements with the printers when they return their proofs.*

Retinitis Pigmentosa and Night Blindness.

By A. W. ORMOND.

We are accustomed, when speaking of vision, to limit our statement to what is really only a part of our sight, viz., our visual acuity—that is, our capacity for seeing clearly and distinctly objects, the images of which fall upon our macula; but vision is a much more comprehensive thing than that, and comprises not only our visual acuity, but also our colour vision, our ability to see things we are not looking at, but which fall within our field of vision, and also our power of adaptation to variations in the intensity of light in which the objects we look at are seen.

Our inability to see on passing suddenly from a well-lighted room into darkness, or from a dark cellar into the full sunshine, is due to the fact that the retina requires a certain time to adapt itself to the altered light conditions; the time necessary for this to take place varies with different people, but normally it is only a few seconds. In pathological conditions, however, the time may be very much prolonged, even to hours, and in some cases the retina is unable to adapt itself at all.

Night blindness, or nyctalopia, is due to such a want of adaptation. By "night blindness" is meant an abnormal degree of impairment of vision at night or whenever the light is dim. The degree of impairment ranges in different cases from slight embarrassment to practical blindness. During the day, or in a good light, the vision may be of normal acuteness, but it fails rapidly at dusk.

It is somewhat amusing to find that the terms nyctalopia and hemeralopia, by which are meant night blindness and day blindness, have become interchanged owing to an academic dispute as to the origin of these words from the Greek, and you will find American writers using the term nyctalopia to mean day blindness, and hemeralopia to mean night blindness. I am adhering, however, to the nomenclature of the Royal College of Physicians, which embodies the old and original meaning of the terms.

We have recently had two children, one a boy and one a girl, brought to us in the Out-patient Department by puzzled and rather indignant mothers, with the history that when dusk comes on the children cannot see, but tumble over things and behave as if they were blind. This phenomenon would, I think, be more often noticed were it not for the improved lighting of our streets and houses, because the transition from good daylight to darkness is very much curtailed by the amount of artificial light. At the same time, we do see about half a dozen cases of this sort in the year.

Some years ago I was told of some sailors who had been temporarily stranded, and had undergone a long period of semi-starvation and exposure, and eventually reached the Dreadnought Hospital at Greenwich, where they were admitted in order to recuperate. On the day after their admission they were being transferred from one part of the building to another. In the ward they had not complained about their sight, but on being taken down a long and rather dim passage they all declared their inability to see, and it was not until they reached the ward again that they regained their sight. We find this same symptom occasionally in Russia after the long religious fasts, also, in the early stages of scurvy, in certain disorders of the liver, in anæmia, and in pregnancy. In all these conditions night blindness is only a temporary condition, and recovery is usual.

We have, however, a group of diseases in which night blindness is the earliest and most important symptom, and in which the phenomenon has no tendency to disappear. This group of diseases is characterised by well-marked pigmentary and other changes in the retina, and in their most typical form constitute the disease known as retinitis pigmentosa.

In a typical case of retinitis the earliest symptom is night blindness, the patient stating that it has been present for a long time, often as long as he can remember, and its insidiousness prevents him from saying exactly when it started, but his inability to see in a dim light increases, and gives him more and more inconvenience. On ophthalmoscopic examination the optic disc is noticed to have an altered appearance. The vessels, arteries, and veins are smaller. The disc itself has a uniform appearance and seems to be made of wax, all detail being obliterated. Around the disc and in the macular region the fundus shows a conspicuous defect in the pigment of the hexagonal cells, but beyond this we find the typical "bone-corpuscle" pigmentation, and beyond this again, that is, at the furthermost limits of the ophthalmoscopic field, we find the retina once more unpigmented.

The field of vision, if tested carefully with a very small test object, will reveal an absolute or

relative ring scotoma corresponding to this pigmental area.

The central vision is usually good, and the patient can see well in a bright light. Both eyes are similarly affected, and there is generally a star-shaped opacity at the posterior pole of the lenses. A history of other members of the family being similarly affected may often be elicited.

The disease usually starts in early life, continues throughout middle life, and eventually reduces the patient to blindness.

Cases such as these are rare, but cases which may be atypical cases of retinitis pigmentosa are not so rare. It is obvious that since the disease is so very chronic and progressive, the symptoms will undoubtedly vary with the stage which the disease has reached when the examination is made, and this in some measure accounts for the fact that so many cases of atypical retinitis pigmentosa have been described; also it is undoubted that chronic inflammatory disease of the choroid may simulate the ophthalmoscopic appearances of retinitis pigmentosa.

Probably many of those cases of retinitis pigmentosa with impaired central vision are of long standing, as well as those with vision too defective to notice any difference in a bad light, or where, the central vision being absent, the patient sees *better* in a dim light.

There are, however, certain groups of cases to which distinctive names have been given, and to which I shall refer later, which are clinically or ophthalmoscopically allied to true retinitis pigmentosa. I refer to two groups described by Fuchs, viz., Atrophia Gyrata Choroidæ et Retinæ, and Retinitis Punctata Albescens.

Cases of unilateral retinitis pigmentosa have been recorded, and Mr. Nettleship has published some cases in which all the subjective symptoms of pigmentary degeneration of the retina were present, but no pigment could be seen ophthalmoscopically, and, lastly, the cases of so-called congenital stationary night blindness must be mentioned.

Heredity is found in about 23 per cent. of the cases (Nettleship), and consanguinity of the parents in about the same number. The disease is much commoner in males than in females, and is frequently found amongst deaf mutes and idiots.

There is sometimes difficulty in diagnosing primary degeneration of the retina with pigmentation, from pigmentation of the retina following choroiditis. The doubt is set at rest by the presence of patches of true choroidal atrophy which do not occur in retinitis pigmentosa, although in the primary disease, in very advanced cases, the choroid becomes atrophic as well as the retina.

Also the pigmentation in true retinitis pigmentosa may not conform to the delicate "bone corpuscle" form, but may be in the form of round blobs, not following the course of the vessels at all.

Retinitis pigmentosa, then, is characterized by its hereditary nature and its occurrence in families, its commencement in childhood, its slow but uninterrupted progress, the initial symptom of night blindness, and the atrophy of the retina.

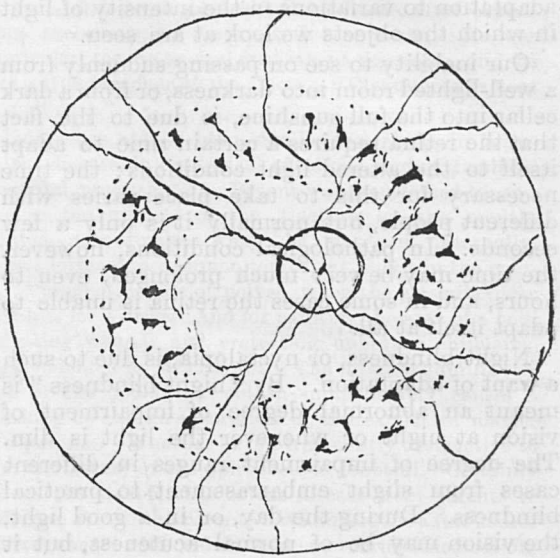


Diagram to indicate the position of the pigmented zone in Retinitis Pigmentosa.

Cases of retinitis punctata albescens have all the above characteristics, except that the ophthalmoscopic appearances show small white discreet dots scattered all over the fundus without any pigmentation at all, and without marked changes in the optic disc or retinal vessels.

Cases of atrophia gyrata choroidæ et retinæ are distinguished, on the other hand, by the presence of circular patches of choroidal atrophy which constantly increase in size, until at length only small islands of normal retina are left. These islands may be connected by long thin strands of normal tissue, forming a circular chain enclosing large areas of atrophied choroid and retina.

Pathology.—Our knowledge of the minute anatomical changes present in cases of pigmentary degeneration of the retina depends on the examination of only a few cases, but most observers agree as to the actual changes found, and it is not until we consider the deductions drawn from these investigations that we find ourselves involved in conflicting ideas.

The pigment is found invading the inner layers of the retina. The rods and cones are absent, as also are the nerve elements of the retina, and a fibrous degeneration of the retina is seen in advanced cases. The choroid also is atrophic. The changes in the retina are noticed earlier, and are more marked in the outer layers of the retina; there is thickening and sclerosis of the blood-vessels, and the pigment is found mostly in the course of the vessels. There are marked changes in the pigment epithelium, and some small exudative patches undergoing fatty degeneration are noticed between retina and choroid.

From these findings there is no great dissension, but almost every observer has interpreted the facts differently.

Two main differences are found, the one which suggests that the changes are inflammatory in origin, and the other that the changes are degenerative.

The Nettleship-Gonin theory attributes the disease to an obstruction of the blood current in the chorio-capillaris, and the majority of observers attribute the disease to an interference with the circulation in the choroid.

On the other hand, it has been assumed that the condition is primary in the retina, and that it is a primary atrophy of the retina, and the choroid is involved secondarily. Doyne has recently expounded a theory, based entirely on clinical observation, that the disease is due to some "exudation which infiltrates the retina, fills up the physiological cup, and gives a waxy appearance to the disc, producing, perhaps, 'drusen' bodies, and the excessive fibrous tissue that is found in the degenerated retina," and he compares the condition found in syphilitic retinitis, where an inflammatory exudation of the retina produces symptoms analogous to those of retinitis pigmentosa.

There are some interesting experiments recorded by Wagenmann bearing upon the subject. Wagenmann succeeded in cutting the posterior ciliary vessels in rabbits and guinea-pigs and found that a pigmental degeneration of the outer layers of the retina resulted over that part of the choroid supplied by these vessels.

(To be continued.)

Dinner to Mr. Cosmo Bonsor.

On Friday, Oct. 28th, the members of the School Staff of Guy's Hospital dined together in the Connaught Rooms. Mr. Cosmo Bonsor, who has for so many years been Treasurer of the Hospital and had given up the office to become the President, was the guest of the evening. Dr. Hale White presided, and almost the entire consulting and teaching staff were present. Dr. Hale White, in an extremely happy and humorous speech, referred to the good work that Mr. Bonsor had done at Guy's, and to the great changes which had taken place in the financial position of the hospital no less than in its buildings. He further pointed out that Mr. Cosmo Bonsor had seasoned his activity with such tact and amiability that he had become the personal friend of those whose privilege it had been to work with and under him. As a sign of their appreciation of Mr. Bonsor, and his work and amiable qualities, the Staff wished to present Mr. Bonsor with some memento of his work and his colleagues. Dr. Hale White then handed to the guest of the evening a silver loving cup, which is a replica of one which is always in the hands of the Treasurer of the Hospital, and a golden cigarette box, upon which were engraved the names of all those who had been on the School Staff during the period of Mr. Bonsor's Treasurership. Dr. Hale White then proposed the toast of Mr. Bonsor's health, which was drunk with acclamation.

Mr. Bonsor thanked Dr. Hale White and his other hosts for their kindly sentiments and their support and help during his Treasurership.

The very successful dinner was followed by music.

Appointments.

Civil.

KENT, H. B., M.B., B.S. Lond., M.R.C.S.Eng., L.R.C.P., has been appointed Medical Officer to the Chinese Engineering and Mining Co., Ltd., and to the Imperial Railways of North China, at Tong Shan.

Military.

Captain H. D. PACKER, R.A.M.C., and Captain LAWRENCE HUMPHRY, R.A.M.C., are promoted to be Majors.

Major C. M. FLEURY, R.A.M.C., has embarked for a tour of service in South China.

University of London.

The following names have been added to the Panel of University Lecturers in Physiology:—

E. L. Kennaway, M.B., B.Ch. Oxon.
J. H. Ryffel, M.B., B.C. Camb.

Edmund Ivens Spriggs, M.D. Lond., F.R.C.P. Lond., has been appointed Medical Officer to the University for five years from October 19th, 1910.

Stocker's Symptom.

ALL Guy's men who were connected with the hospital or school before the end of 1877 will remember with affection and regard one who was of the essence of Guy's for forty or fifty years—Mr. James Stocker, apothecary to the hospital. He lived in the Quadrangle, in the house now occupied by the Matron, and his whole life was devoted to the interests of the hospital and school. Besides being the chief to whom the dispensers were responsible, he was resident medical officer before there were house-physicians, and secretary of the Medical School before there was a Dean. His duties in the first capacity were given up in 1868, when his son, Dr. J. Reginald Stocker became the first house-physician, and in 1874 I became the first Dean of the Medical School, having for three years the advice and assistance of Mr. Stocker, who retired finally in 1877 at an advanced age.

As resident medical officer, going round the whole of the medical wards night and morning, and often visiting the surgical wards, Mr. Stocker had acquired an extraordinary experience, and his clinical acumen was such that the physicians were frequently glad to hear and be guided by his opinion in difficult cases. That tubercular meningitis and typhoid fever can resemble one another closely is a fact one should never forget, and in the days before Widal and lumbar puncture, before even the use of the ophthalmoscope, which was only beginning to be general in medical wards in the late sixties, the difficulties of diagnosis were still greater than they are now.

To Mr. Stocker was due the observation, which he constantly made, and compelled others to make, that in cerebral disease the patient was often irritable, and lay curled up in bed, with the clothes over the face, and resented all interference, and that if the clothes were pulled down the patient replaced them at once; whereas in fevers the patient was dull, stupid and indifferent. It will be gratifying to know that Mr. Stocker's name as a clinical observer will not be allowed to be entirely forgotten. In the appendix to the second edition of a very useful book, the "Terminologia Clinica," of Dr. Luigi Ferrio, of Turin (1909), there is the following notice:—

> **Stocker** *(Sintoma di)*.—Nella meningite tubercolare, prima del periodo comatoso, i bambini, sono stizzosi ed insofferenti; se si cerca di scroprirli si afferrano tenacemente alle coperte del letto per rimettersele addosso.

Which is, *Anglicè*:—

> Stocker (Symptom of).—In tubercular meningitis, before the period of coma, children are irritable and intolerant; if one tries to uncover them, they lay firmly hold of the bed-coverings to replace them.

FREDERICK TAYLOR.

Physiological Society.

The first meeting of the Society was held on Monday, October 31st. Dr. Pembrey occupied the chair, and forty members were present.

Mr. C. H. Gould read an interesting paper, entitled, "Organs of Embryonic Nutrition." He first offered a possible explanation as to the origin and necessity of these organs on Darwinian principles, supporting his views by reference to various lower types, starting with the amœba, which has no organs of embryonic nutrition, and dealing at some length with the elasmobranchs, which offer interesting examples of different modes of nutrition, including the yolk-sac placenta. Having finally arrived at man, he explained the relative positions and importance of the fœtal membranes by comparing diagrams of the human embryo with that of the chick. The mode of nutrition in the case of marsupials was also discussed, and the opinion offered that such a method of reproduction would be of advantage in the case of human beings. Finally, an allusion as to the fate of the placenta was made, its absorption in the case of some animals after birth, and the reason as to why herbivora frequently eat the placenta discussed.

The paper was followed by an interesting discussion, in which the chairman and nine members joined.

The meeting closed with a vote of thanks to Dr. Pembrey for occupying the chair.

The next meeting will be held on November 14th, at 4 o'clock, in Class Room 2, when Mr. S. S. Harrison will read a paper, entitled, "Secretion of Urine."

H. W. EVANS, Hon. Sec.

Change of Address.

E. Hargrave Booth, M.D. Lond., from 1, Cambridge Road, Hove, to 2, Wilbury Road, Hove.

E. M. Harrison, M.B., B.S. Lond., M.R.C.S. Eng., L.R.C.P., from 45, New North Road, Huddersfield, to 42, New North Road, Huddersfield.

H. B. Kent, M.B., B.S. Lond., M.R.C.S. Eng., L.R.C.P., from London, to Tong Shan, North China.

G. L. L. Lawson, M.R.C.P. Edin., L. & L.M., D.P.H., M.R.C.S. Eng., from Duncombe Hill, Honor Oak Park, S.E., to 207, Stanstead Road, Forest Hill, S.E.

B. G. Neale, M.R.C.S. Eng., L.R.C.P. Lond., from Karenza, Clevedon, Somerset, to Two Pools, Iron Acton, Gloucestershire.

Cecil Price-Jones, M.B. Lond., from Guy's Hospital, to 68, Harley Street, W. (*Teleph.* 676 Padd.).

G. J. B. Stevens, M.R.C.S. Eng., L.R.C.P. Lond., from 1, Newington Green, London, N., to 5, Woodbury Park Gardens, Tunbridge Wells.

Nursing News.

Miss L. Greenall, Sister-in-Charge of Patience Ward since April, 1909, was transferred to Stephen Ward on September 16th.

On October 22nd, Miss L. E. Jolley (Sister Eleanor) left the hospital to take up her duties as Matron of the Royal Southern Hospital, Liverpool. Since completing her training in 1906, Miss Jolley has acted as Instructress in the Preliminary Training School, Night Sister and Holiday Sister.

On October 23rd, Sister Hancock, who has been Medical Night Sister since December, 1909, was transferred to Patience Ward.

On October 31st, Miss M. T. Whittingham (Sister Theresa), who has been Home Sister since October, 1908, left the hospital on her appointment as Matron of the Public Hospital, Kingston, Jamaica. On completion of her training, Sister Theresa was appointed Sister of the Isolation Wards, and afterwards Night Sister for a few months. In May, 1903, she was appointed Sister-in-Charge of Mary Ward, which post she held until transferred to the Nurses' Home.

Sister Gardner, who has been Assistant Home Sister since June, has been appointed to succeed Miss Whittingham as Home Sister, and Miss E. J. Lucas, who completed her training in May, 1910, has been appointed Assistant Home Sister.

On September 14th, Nurse Myers left the hospital on completion of her three years' training. Nurse Strappini was appointed to succeed her as Head Nurse in the Eye Wards, and Probationer Stewart was appointed Head Nurse in Victoria Ward.

On September 21st, Nurse A. Brown, Head Nurse in Bright Ward, left the hospital on completion of her three years' training, and Probationer Yates was appointed to succeed her as Head Nurse in Bright.

On September 23rd, Nurse Woollett left the hospital on completion of her three years' training, and Probationer Pearman was appointed to succeed her as Head Nurse in Stephen Ward.

On September 26th, Nurse Salmon, Head Nurse in Addison Ward, left the hospital on completion of her three years' training.

On October 14th, Nurse D. Carey, Head Nurse in Charity Ward, left the hospital on completion of her three years' training. Nurse E. Foster, Head Nurse in the Surgery, was transferred to Charity Ward, and Probationer C. Orchard was appointed to succeed her as Head Nurse in the Surgery.

On October 15th, Nurse Rose left the hospital on completion of her three years' training, and Probationer MacManus was appointed to succeed her as Head Nurse in Mary Ward.

On October 20th, Nurse McAra left the hospital on completion of her three years' training, and Probationer Drew was appointed to succeed her as Head Nurse in Astley Cooper Ward.

On October 22nd, Nurse E. Fisher, who completed her three years' training in August, and has since been doing Sisters' holiday duty, left the hospital to take up the appointment of Sister at the Schiff Home of Recovery, Cobham, Surrey.

On October 24th, Nurse G. Wallis left the hospital on completion of her three years' training, and Probationer Dowley was appointed to succeed her as Head Nurse in Bright Ward.

On November 1st, Nurse Barker, Head Nurse in Mary Ward, left the hospital on completion of her three years' training; Nurse Jolliffe was transferred to Mary Ward, and Probationer Tilleard was appointed to succeed her as Head Nurse in Victoria Ward.

On November 1st, Probationer M. Blenkarn was appointed additional Head Nurse in the Eye Wards.

On November 3rd, Nurse E. Blenkarn left the hospital on completion of her three years' training, and Probationer Keeble was appointed to succeed her as Head Nurse in Stephen Ward.

The result of the Probationers' Examination on Nursing subjects, held in September, is as follows:—

First Class.—Pro. Balkwill, Battley, Beardshaw, Bollard, Brereton, de Carteret, Cobbald, Colston, Davis, Dicken, Douglas, C. Edwards, Evans, G. Fletcher, E. Fletcher, Fothergill, Freshney, Garnett, Gilkes, Gooderham, Greaves, Gwilliam, Hansen, Hawkins, Hewitt, Hirst, Hutton, Jagger, Johnson, G. Jones, Lay, Lewin, Malkin, Mansfield, Masters, Maughan, G. Moore, Millar, Middleton, Oliver, Patterson, Paul, Pearson, W. Pearson, Phillips, Probert, Randles, Roach, Rudd, Scott, Selby, Sherrard, Sime, M. L. Simpson, Stevens, Strange, Sutherland, Templeman, Thomas, Trice, Weighill, Willett, Windley, Witchell.

Second Class.—Pro. Bagnall, M. Coulton, K. Dickson, L. Dickson, H. Edwards, Foxon, Howard, Hughes, Jordan, Mallonek, O'Rorke, Percy, Pike, Purves, Servais, S. Simpson, Skou, Spurway, Squire, Sterling, Stretton, Teague, C. Thorpe, Twose, Wittrick.

At the Exhibition of Invalid Cookery, held under the auspices of the Cookery and Food Association, at the Horticultural Hall, Westminster, on November 3rd and 4th, Guy's Nurses gained the highest total of marks. Eight trays were sent in, and the Jury Committee made the following awards:—

Silver Medals.—Nurse McKenzie Kennedy, Pro. Paul, Pro. Hodgkinson, Pro. McLaren, Pro. Oldershaw.

Bronze Medal.—Pro. Jagger.

Certificates of Merit.—Pro. Grant, Pro. Schlagentweit.

Miss Margaret Traill has taken up her duties as Matron of the new Schiff Home of Recovery at Cobham. Miss Traill was Sister at Guy's for nearly six years, and Matron at the Royal Surrey County Hospital, Guildford, for about the same length of time.

We deeply regret the death of Miss Maud C. Martyn, at Liskeard, on Friday, October 21st, 1910, which was recorded in the last issue of the GAZETTE. Miss Martyn entered Guy's as a Probationer in March, 1897, and on completion of her three years' training acted as Night Sister for three months, becoming Sister-in-Charge of Charity Ward in September, 1900, until December, 1905. She was much beloved by her patients, being untiring in her efforts to do all she could for them; it war therefore a great sorrow to her when she was compelled to give up her duties on account of ill-health. During the last few months Miss Martyn wrote such good accounts of herself that the news of her death came as a great shock to those of us who knew her. At the beginning of October she was well enough to go away with her sister for a change of air, but on the 14th she became acutely ill, and died on the following Friday. The funeral took place at Newquay on October 28th.

Sport.

Rugby Football.

GUY'S v. LENNOX.

This time-honoured fixture was played at Honor Oak Park on Saturday, October 29th, and though the Hospital won, there was very little margin to boast of. Several men were away, and others perhaps a little stale after the Cambridge match. But the real reason of the close game was the excellence of the Lennox forwards, a heavy and fast pack, who used their feet in the loose and were very smart to break up and go on with the ball. Heavy rain had fallen in the morning, and there being "no dry" about in the atmosphere the ground and ball became very slippery. Guy's frequently got the ball from the scrum, but Saner's neat work was not taken advantage of to the full; the passing, not unnaturally, broke down, and not till quite late in the game did the wingmen get real opportunities of showing their worth. Saner sent a pass out to Medlock which unfortunately went very wide of the latter. The Lennox forwards seized the opening, carried the ball by a great rush upfield and over the line for Leney to score an unconverted try. This was all the scoring in the first half, but once after some good handling Stokes went over, but in an ill-judged attempt to get a good position went over the dead-ball line. Half-time then taken.

Directly the second half commenced Stranack and Hind rushed the ball to the Lennox line and Medlock picked up very neatly and scored behind the goal-posts, adding the extra points himself. Lennox, with Leney, Haxell and Craston always well to the front, tried their utmost to get on terms. Millett at full back, who was distinctly good, held them back, his tackling and touch-finding earning applause frequently. Once Newbery got clean away with only Millett to beat, but the latter brought off a lovely low tackle. A penalty to Guy's brought no addition. Then a fine passing run, and Stokes was only pulled up a couple of yards the wrong side. Next Flooks dribbled over and raced two Lennox men for the touch-down. It looked as though Flooks was first on the ball, but the referee ruled otherwise. However, by neat footwork, Flooks dribbled over again, and Stringer, who was in close attendance, secured the try. Glendining missed the goal, and a well-fought-out game ended in Guy's favour by 1 goal and 1 try to 1 try. Team:—

GUY'S.—H. Millett (back); L. B. Stringer, T. Flooks, G. E. W. Lacey, A. L. Stokes (three-quarters); J. G. Saner, C. H. Medlock (halves); G. R. Hind, W. S. Stranack, M. Tweed, A. W. A. Davies, H. Hoby, O. Parry Jones, V. Glendining, A. Sportsman (forwards).

REMARKS.—Guy's were short to commence with, but a very sporting confrère, who belongs to another hospital, kindly donned Kentish Blue and turned out. His action was greatly appreciated. The forwards did not get going from the scrums with "heads up" quick enough, but when it came to heeling they beat the Lennox men for possession. The forwards must also tackle low. Follow Hind's example; no better pattern can be wished for. It was scarcely a day for back play, but much of the work behind was wild; the slippery ball accounted for much. Stokes shows much more determination; he improves with each game. Flooks and Lacey as insides did very well. Stringer did many good things, but was not very fit; he was still feeling the effects of two kicks from the previous Wednesday. Millett gave a very excellent display. It is comforting to know that such a good full back is at the hospital's call.

GUY'S v. STREATHAM.

A wretched mist hung over the ground at Honor Oak Park on Saturday last, November 5th, and just at first it was a little doubtful as to whether play would be possible. But the haze lifted and the game eventually commenced somewhat late.

From the first Guy's took the game in hand, and though the eventual margin won by was not very great, it was not altogether the fault of the Hospital men that the total was not greater. The first score was not long delayed, as Guy's forwards had clearly shown that they were going "all out." A footing was established in the Streatham twenty-five, where Flooks gave Stringer a good pass while he was going at top pace; the result was a brilliant burst over the line and a try behind the posts. Stokes goaled. Later, Flooks, noticing Stokes unmarked, gently "soccered" the ball in his direction, Stokes throwing himself over the line for a try, too wide out to kick a goal from.

It should be pointed out that for some time Streatham had been one man short. Muncy was badly kicked on going down pluckily, and though he remained on the ground, he was of very little service after.

The second half was practically a repetition of the first, except that Dawday, who went half-back, *vice* Muncy, seemed to play more offside than on, much hampering Saner and preventing much open play. Stringer was responsible for both tries in the second half. The first one, after all the "threes" had handled, was the outcome of a clear pick-up and momentary dash for the line, nonplussing the Streatham backs, the second, the result of some "brainy" play on Medlock's part. Hemmed in, Medlock passed very widely to Stringer, who gathered and got round behind again. Stokes goaled, and this ended the scoring. Lacey picked up and fielded the wet ball with great skill throughout the game, while the re-appearance of C. S. L. Roberts was a great source of satisfaction to his numerous admirers at Honor Oak Park. Guys, 2 goals, 2 tries (16 pts.), Streatham, nil. Team:—

GUY'S.—G. E. W. Lacey (back); L. B. Stringer, T. Flooks, A. S. Roe, A. L. Stokes (three-quarters); C. H. Medlock, J. G. Saner (halves); A. V. Moberly, C. S. L. Roberts, R. S. Kennedy, M. Tweed, A. W. A. Davies, V. Glendining, O. Parry Jones, C. Gibb (forwards).

GUY'S HOSPITAL v. OXFORD UNIVERSITY.

Before a large crowd, among whom we were glad to see Dr. Frederick Taylor, and under the best conditions, this match was played at Honor Oak Park on Wednesday, November 9th. The result 32 points (4 goals 4 tries) to nil in the University's favour.

It was very disappointing, especially as the game wore on and Guy's lost more ground, and then Stokes was compelled to go off. The Hospital's chances rapidly waned, and instead of looking forward to a win it became a question of by how much would they lose. But there is no need to be discouraged, The University played a splendid game; hard, clean, and very fast, and their movements were so bewildering that few sides would have been able to defeat them on such form. Poulton and Buchanan were splendid, and after Stokes left, the pace of these men with Geen on the wing, quite nonplussed for pace and cleverness the Guy's right flank. The remarks that follow this report will criticise individually. But with two exceptions the Guy's tackling has never been so bad, men going high, hesitating, and failing to go for the man with the ball.

The first try after some ten minutes' play was gained by Hands, the second by Geen. Lacey should have collared Geen, but he got clear. Neither try was converted, though Lagdon easily goaled a try by Turner before half time. It was a fine try. Poulton in top form swerved and dodged (all at a great pace), cleared the field, the Oxford pack became threequarters, backing up to a man. Turner received last of all and grounded. Before half-time Stokes was effectually tackled by Sampson, and Medlock went well, but his pass was mulled. Half-time arrived with Oxford leading by 11 points.

Resuming, Guy's pressed for a bit. Stokes kicked over and the ball rolled dead. But in the movement Stokes' leg gave way and he had to retire with strained thigh muscles for the remainder of the play. The Guy's play now fell away, although, strange to relate, the seven forwards (Tweed having been shifted to the threequarter line) appeared to be playing better, but nothing came off for Guy's, and Oxford, who went from good form to the very best, commenced to pile on the points, 2 more tries were scored by Geen, 1 each by Steyn, Poulton, and Buchanan. Turner converted one and Lagdon two tries, so that the final score read as above. Team:—

GUY'S.—G. E. W. Lacey, back; L. B. Stringer, J. P. Jones, A. S. Roe, A. L. Stokes, threequarters; P. J. Monaghan, C. H. Medlock, halves; G. R. Hind, A. V. Moberly, C. S. L. Roberts, W. S. Stranack, R. S. Kennedy, A. W. A. Davies, M. Tweed, and C. Gibb, forwards.

OXFORD UNIVERSITY.—F. H. Sampson (Trinity), back; W. C. Geen (University), R. W. Poulton (Balliol), F. G. Buchanan (Trinity), and S. Steyn (Lincoln), threequarters; W. J. Cheeseman (Wadham) and F. H. Nott (Brasenose), halves; F. H. Turner (Trinity) (Capt.), R. O. Lagdon (Oriel), R. Honey (University), L. G. Brown (Balliol), H. S. Sharp (University), A. Gilmour (Trinity), D. M. Bain (Trinity), and P. Hands (University), forwards.

REMARKS.—To say that the result of the game was a disappointment is to express one's feelings mildly, and it was a disappointment accentuated by a feeling that the team did not do itself justice. The feature of the game was the breakdown of the forwards. With the exception of Hind, Stranack and Roberts, the pack played an exceedingly poor game, in contrast to their previously excellent play this season. Time and again one or two Oxford forwards were unmarked from touch, and the forwards' tackling was, with the exception of Hind, who did some remarkably good work, very weak. The Oxford pack got the ball in the majority of scrums, but even when the hospital forwards did get possession, the back row did not let it out cleanly. Behind the scrum Saner was badly missed, as Monaghan (who turned out in a most sporting manner), although working hard, was terribly slow in getting the ball away. Medlock played a sound game, and seems to be learning at last that it is the business of a stand-off half to feed his centres, and not to stick to the ball himself. Jones, although obviously unfit, did all that he could do to stem the tide of disaster, and several of his "pick-ups" were quite in his best style. Roe was obviously out of practice, and appeared slow, but worked hard. Stokes unfortunately had to leave the field shortly after half-time, but, until then, played an excellent game, running hard and straight, and kicking with excellent judgment. Stringer, too, was fair, and was several times unfortunate in slipping at the beginning of a run. Lacey, at back, was more uncertain than he usually is, but put in some good saves. The whole team showed a disinclination to go for the man with the ball, a principle without which all defence will and must break down, and several missed catches gave our opponents ground we could ill afford. We noticed a tendency on the part of several of the team to pass in front of their own goal, a very dangerous practice, which nearly cost the hospital some extra points. Unfortunate as was the result, a good beating is an excellent stimulant, and we trust that the side, which is undoubtedly a fine one, will do itself more credit in its future matches.

Association Football.

GUY'S v. EMERITI.

At Honor Oak Park, on Wednesday, October 26th, and won rather easily by the home side by 4 goals to nil.

The opening half was more or less even, though the Emeriti could not reply to the two goals scored for Guy's by Birks and Bergh.

On resuming, the hospital practically controlled the game, and only the visitors' goalkeeper, by excellent keeping, kept down the score. Many shots, however, were feeble in direction and power, and the forwards frequently dribbled to the goal-line before attempting to shoot. The defence managed very well, and effectively stopped the spasmodic efforts of the Emeriti. Goals were scored in this half by Veale and Bergh. Team:—

GUY'S.—H. C. Rook (goal); K. J. T. Keer, S. H. Russ (backs); W. T. Wallis, H. B. Neely, A. F. Camp (half-backs); C. E. Rice, V. E. D. Bergh, R. M. Veale, A. H. Birks, S. W. Bevis (forwards).

GUY'S v. MERTON.

SURREY A.F.A. SENIOR CUP.—2ND ROUND.

Although playing on their own ground Guy's could only effect a draw in this tie, on Saturday, October 29th. Our opponents, a new club this season, were very keen, and played determined football; they knocked the Guy's team off their game, and very nearly won the tie. It would seem that the hospital should have adopted similar tactics (the same remark applies to the Beckenham match), namely, long though accurate kicking from wing to wing, determined, though not wild, rushing, with the defence well backing up. But the forwards played their own game, and it was not made easier by the slippery surface of the ground.

Although a goal down at the interval the Hospital XI. had their full share of the play, and everyone expected them to go ahead in the second half, which they did, and for twenty minutes the forwards played delightfully. Veale converted an excellent centre by Bevis, and Bergh sent in a fine shot which also found the net. The hospital maintained their lead till within ten minutes of time, when Merton took up the running in determined fashion. With Kyle and Camp doing little at half, owing to injuries, their way was made easy; but their equalising goal came from the right wing, Rook apparently failing to get sight of a long shot from thirty yards out; he saved brilliantly from a penalty, given for some occult reason against Keer, a short time before. Thus an unsatisfactory game, from a Guy's point of view, ended in a draw of 2 goals all. Team :—

GUY'S.—H. C. Rook (goal); K. J. T. Keer, S. H. Russ (backs); A. F. Camp, J. Kyle, H. B. Neely (half-backs); C. E. Rice, V. E. D. Bergh, R. M. Veale, A. H. Birks, S. W. Bevis (forwards).

REMARKS.—King was badly missed, and the inside forwards were only good at times, while Bevis was badly handicapped by having no studs. Russ at left back is certainly a find; he should have no difficulty in keeping his place, and in time he should prove a worthy successor to Bastard. Keer plays a good game, and tackles well; he is inclined to balloon at times, and lacks weight, which, however, is hardly his fault.

GUY'S v. MERTON.

REPLAYED CUP TIE.

At Merton, November 5th. Guy's 5 goals; Merton, 0.

Guy's made no mistake the following week with the replay of this tie. King, returned from Bohemia, came into the side, which was further strengthened by the inclusion of T. H. Edey and J. Bastard, two tried warriors, who gave a very good account of themselves. They took the places of Kyle and Camp (both crocked) for this match because 2nd XI. men by playing in 1st XI. ties are debarred from playing in their own ties.

Merton pursued the same methods as last week, and looked dangerous at the start, but within ten minutes King sent across a typical centre, and Birks shot hard into the net. Bergh followed this up with an individual effort and a brilliant shot from thirty yards out, which gave the goalkeeper no chance (2—0). Merton played up hard after this and came very near scoring on one or two occasions, their left wing causing most trouble.

Immediately after half-time Bergh put in another fine shot, making the score 3—0, and the next minute King ran down and centred, an obliging Merton back doing what was necessary (4—0). Merton fell off after this, their backs and centre half, who had played up very hard, tired, and Guy's were often dangerous. Excellent goal-keeping kept down the score, although Bergh added one more, from a fine pass by Veale, before the end, making the final score 5--0. Team :--

GUY'S.—H. C. Rook (goal); H. R. Bastard, K. J. T. Keer (backs); T. H. Edey, H. B. Neely, S. H. Russ (half-backs); R. M. King, V. E. D. Bergh, R. M. Veale, A. H. Birks, S. W. Bevis (forwards).

REMARKS.—The team may be congratulated this week upon a thoroughly good display; they seem to play really well about once in three weeks. The forwards, with a competent defence against them, did excellently in scoring five times. Bergh's two shots deserve special mention. Birks gets hold of awkward passes with great skill, and feeds Bevis to perfection; the latter was much improved, and certainly does not spare himself. Veale does a lot of good work which leads to others getting goals, while King and Bergh were in their best form. The defence had plenty to do. Edey and Bastard were more than useful; Keer's volleying was not always accurate, and he must try and keep the ball in play more than he does, otherwise he was very good; Russ was safe and energetic. Rook in goal was not often troubled, though he saved well once or twice.

Papers by Guy's Men.

A. E. Boycott, M.A., M.D. Oxon: The Action of Oleic Acid and its Soaps on the Blood.—*British Medical Journal*, 5th November, 1910.

C. H. Fagge, M.S. Lond., F.R.C.S. Eng.: A Lecture on the Complications of Gall-Stones.—*The Clinical Journal*, 2nd November, 1910.

G. W. Goodhart, M.A., M.D. Cantab.: Chloroform Necrosis of the Liver.—*British Medical Journal*, 5th November, 1910.

Birth.

MORGAN.—On Tuesday, October 25th, 1910, at Groombridge, Sketty, R.S.O., Glam., the wife of Edward Morgan, M.R.C.S., L.R.C.P., of a daughter.

PARTRIDGE.—On October 23rd, at St. German's, Sutton, the wife of A. A. H. Partridge, M.A., M.D. Oxon., of a son.

ED.—E. G. S. p.p. A. N. C.

GUY'S HOSPITAL GAZETTE.

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Death of a Governor.

MR. WALTER SCOTT SETON-KARR, whose death at the age of eighty-eight was announced last Tuesday, was, for some years, a Governor of Guy's Hospital. He was elected in 1882, in the same year as our President, and was remarkably regular in his attendance at the meetings of the Governors, even recently, in spite of his advanced age.

Mr. Seton-Karr was a son of Mr. Andrew Seton, the East India Company's Commercial Resident at Maldah, who, in 1815, inherited the estate of Kippilaw, near Abbottsford, and in accordance with the entail provision, took the additional surname of Karr. Sir Walter Scott was on intimate terms with Mr. Andrew Seton-Karr, and took great interest in young Seton-Karr, who was his godson and namesake, and in after-life delighted to relate his reminiscences of the great novelist.

Mr. Walter Scott Seton-Karr was educated at Rugby (where he took part in the football match described in "Tom Brown's Schooldays") and at Haileybury. He then entered the Indian Civil Service, and held the Under-Secretaryship in Bengal from 1847 to 1853. He presided over a Commission of Inquiry into the indigo riots in Bengal, which occurred a few years after the Mutiny. In 1862 he went to Calcutta as a Judge of the High Court. Before retiring from the public service in 1870, he spent two years as Foreign Secretary to the Government of India, and he was also Vice-Chancellor of the University of Calcutta.

During his years of retirement, besides his association with Guy's Hospital, Mr. Seton-Karr was a Governor of Marlborough College, was for many years on the Chelsea Board of Guardians, and took an active part in other charitable and educational work. He was on three occasions unsuccessful by narrow margins as a Conservative candidate for Parliament. He was renowned as a shot and angler, and even in his later years went regularly to Scotland every Autumn to practise his favourite sports.

Passim.

ON November 17th, the Treasurer, with the members of the Hospital and School Staff, visited the Medical School Buildings in order to unveil a bust of the late Dr. Horrocks, which has been placed in the new entrance hall. Lord Goschen explained that the bust was the gift of Mr. Walter Horrocks, brother of the late Dr. Horrocks, and moved a vote of thanks to him for the gift. Mr. Horrocks briefly replied. The bust, which is in bronze, is the work of Mr. John Cassidy. The inscription runs as follows:—"Peter Horrocks, M.D., Obstetric Physician 1883—1909. Born 1853. Died 1909."

ON Tuesday, December 13th, the Orchestral and Choral Societies will hold the first of their Winter Concerts, at 8.15 p.m., in the Physiological Theatre. A particularly attractive programme has been arranged by Dr. Eason and Mr. Clive Carey, including "The Lotus Eaters," arranged by Villiers Stanford for chorus and orchestra; a Suite for pianoforte and strings, by

A. L. Gardner, and many other attractive items. Tickets, price 2/6, may be had from the Matron, from any member of the Committee, or from the Secretary, L. C. Dundas Irvine.

THE work of the Out-patient Department is to be facilitated by the appointment of a number of qualified Clinical Assistants. The Governors have lately approved of the following regulations relating to these posts:—"(1.) That in each special Out-patient Department, except the Skin and Orthopædic Departments, there shall be a qualified Clinical Assistant, who shall be styled the Chief Clinical Assistant, and that he shall be responsible for the conduct of the department in the absence of the physician or surgeon to the department. He shall be unpaid, except in the case of the two Eye Departments, and shall be appointed for twelve months. (2.) That, in addition, not more than two qualified Clinical Assistants may be attached to each special department, and that it shall be their duty to assist in the examination and treatment of the patients, and carry out investigations as may be directed, but that they shall not be responsible for the conduct of the department in the absence of the physician or surgeon to the department. The Clinical Assistants shall be unpaid, and shall be appointed for six months." Time alone can show how popular these appointments are likely to become. Those who are reading for higher examinations, and desire to specialise to some extent, will appreciate the valuable experience which they offer. The Out-patient Departments, moreover, ought to work more smoothly and with greater efficiency as a result of these appointments.

THE first appointments to these new posts have already been made, Mr. C. H. Mills having been appointed Chief Clinical Assistant to the Genito-Urinary Department, and Mr. W. Johnson Clinical Assistant to the Neurological Department.

THE Milroy Lectures at the Royal College of Physicians next year are to be delivered by Dr. A. E. Boycott, and the Goulstonian Lecture by Dr. Hertz.

AMONG the many minor improvements which are taking place in the Hospital, one is especially pleasing to us, as it was advocated in these columns some time ago. This is the new room which has been provided for the storage of bound volumes of medical reports. The room is on the ground floor of the Medical Building, next to the Clinical Laboratory. It contains shelf room for all the old volumes of reports, and there is abundant room for extension. A writing-table has been provided, and the looking-up of old reports is now a pleasure instead of, as it has been in the past, a misery.

WE desire, in a series of short articles, to give a history of the games and sports in which Guy's has taken a prominent part in former years. Naturally, a start will be made with Rugby Football. It will be necessary for this purpose to have the assistance of as many old players and others interested in the game as possible, and we therefore appeal to all such to let us have any facts or anecdotes which may be of interest. In particular, we should be glad to hear of important dates in the history of Rugby Football at Guy's, the names of players in the past who have been internationals, and the names and addresses of old captains.

THE Lord Mayor of London will open a Conference of Health-promoting Institutions, to be held at the Guildhall on December 8th and 9th, which is being organised by the National League for Physical Education and Improvement. The subjects and speakers at the three sessions are as follows:—1. How to work a "School for Mothers;" Lady Meyer, Vice-president of the St. Pancras "School.' 2. Infant Welfare Schemes Abroad; Miss H. M. Blagg. 3. Day Nurseries; Muriel Viscountess Helmsley, Chairman of the National Association of Day Nurseries. 4. What may be accomplished by Children's Care Committees; Miss M. Frere, Member of the Education Committee of the L.C.C. 5. Health Societies: their Aims and Opportunities; Mr. Douglas Eyre. 6. The Co-ordination of Health-promoting Agencies; Mr. F. E. Fremantle, County Medical Officer of Health for Herts. The chair will be taken at the various sessions by Alderman Broadbent, of Huddersfield, the Duchess of Marlborough, Mr. Whitaker Thompson, Chairman of the L.C.C., and Sir Shirley Murphy, Medical Officer of Health to the L.C.C. Tickets of admission may be obtained gratis on application to the Secretary of the League, at 4, Tavistock Square, W.C.

At Dr. French's Out-Patients.

Two Cases of Locomotor Ataxy with absence of the Knee-jerk upon the Right Side, but with a Knee-jerk of normal briskness upon the Left.

The two following cases exemplify the fact that one knee-jerk may be present and the other absent in cases of locomotor ataxy:—

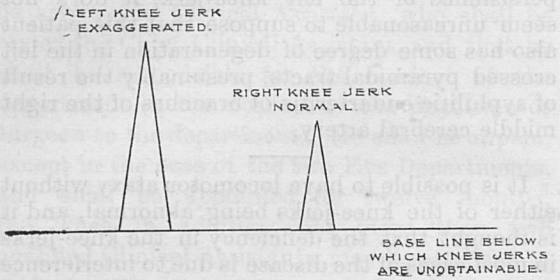
CASE 1.—Charles N., aged 59, a draper, had syphilis as a young man, but has always enjoyed good general health. He now presents a moderate degree of ataxy, and has complained of cramp-like pains in the legs. His pupils are nearly always unequal, the left being much larger than the right; the left pupil reacts moderately to light and well to accommodation; the right reacts to accommodation, but to light, although it moves, it does not remain small, but oscillates (hippus), and whilst still exposed to light it becomes in a few seconds the same size again as it was before the light was thrown into it. The hands are unaffected. The legs present moderate ataxy, especially when the patient is turning round. The right knee-jerk is absent; the left is easily obtained, being approximately of normal briskness. There is no ankle-clonus upon the left side, nor is either plantar reflex extensor. The tendo-Achillis jerk is just obtainable on the left side, not on the right. It is possible that the presence of the knee-jerk upon the left side and its absence upon the right, in this case, is due to the fact that, in addition to locomotor ataxy, he appears to have had some kind of an attack, early in 1908, of the nature of left hemiplegia, due, doubtless, to syphilitic endarteritis of the right middle cerebral artery. There is, however, no other evidence of this former hemiplegia now than the presence of the knee-jerk upon the left side. Whether there was a time in this patient at which both knee-jerks were absent, the occurrence of the left hemiparesis then causing the left knee-jerk to reappear, cannot be ascertained.

CASE 2.—James D., aged 60, had syphilis as a young man, but has always been, and still is, in good general health. He has little or no ataxy, but has complained of cramp-like pains in his legs. He has had no crises. The pupils at once attract attention from their very small size; they are equal, and both of them present the Argyll Robertson reaction. The arms are normal. The legs present entire absence of the right knee-jerk, whilst the left is of normal briskness; the plantar reflex is not constant in its behaviour, but generally it is of the extensor type upon the left side, the right being flexor when the big toe moves at all. Neither tendo-Achillis jerk is obtainable. The right vocal cord is paralysed, the huskiness due to this having been the first symptom that brought the patient to the hospital. There is no history in this, as in the former case, of any attack of hemiparesis, but from the presence of occasional, if not permanent, extensor plantar reflex upon the left side, in conjunction with the persistence of the left knee-jerk, it does not seem unreasonable to suppose that this patient also has some degree of degeneration in the left crossed pyramidal tracts, presumably the result of syphilitic endarteritis of branches of the right middle cerebral artery.

It is possible to have locomotor ataxy without either of the knee-jerks being abnormal, and it is thought that the deficiency in the knee-jerks in most cases of the disease is due to interference with the reflex arc between the afferent and efferent nerves at the level of the upper part of the lumbar enlargement, whence the anterior crural nerves take origin. Whether this interruption is due to the inflammatory changes in the posterior nerve roots and their ganglia, or whether it is due to degeneration in the sensory fibres after they have entered the spinal cord, possibly in the posterior root zone of Lissauer, has not been determined, but it is clear that if the lesions of locomotor ataxy were to affect the cord only above the lumbar enlargement, both the knee-jerks would persist. This being so, it is only going one step further to suppose that sometimes the inflammatory and degenerative changes extend along the cord a little further down upon one side than upon the other in a few exceptional cases, so that they might involve the upper part of the lumbar enlargement upon one side and not upon the other, the knee-jerks being thereby rendered unequal in the early stages, whilst, later, that which began to diminish first might become absent before the other, and thus produce a condition in which one knee-jerk was gone whilst the other still persisted.

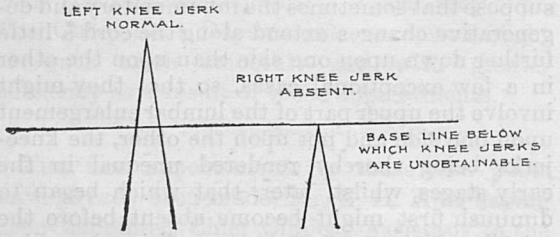
Owing, however, to the history of possible hemiparesis in one of the above cases, and to the presence of a definite, if not constant, extensor plantar reflex upon one side in the other, it seems more probable that a different explanation applies to them, namely, that in addition to locomotor

ataxial changes in the posterior roots and ganglia, in the posterior root zones, and in the postero-internal and postero-external tracts in the spinal cord, they have degeneration of some of the crossed pyramidal tract fibres upon the left side of each of their cords, as the result of degeneration in the region of the internal capsule following upon syphilitic endarteritis of the left middle cerebral arteries. The result of such changes, if they occurred by themselves, would be to cause an increase in the knee-jerk upon the left side, so that if there had been no tabes dorsalis one might represent the comparative strengths of the two knee-jerks as follows:—



Effect on knee-jerks of unilateral crossed pyramidal tract degeneration (left side).

The effect of locomotor ataxy being to diminish both these knee-jerks, the result at a certain stage would be, as in the cases above, to do away with the right knee-jerk and leave a certain degree of left knee-jerk, representing the net balance between the diminution of jerk caused by the tabes and the increase of jerk produced by the crossed pyramidal tract degeneration, as depicted in the following diagram:—



Effect on knee-jerks of unilateral crossed pyramidal tract degeneration (left side) together with tabes dorsalis.

It is even conceivable that a patient might suffer from typical locomotor ataxy with absence of both knee-jerks, and then for the occurrence of hemiplegia upon one side to bring back the knee-jerk upon that side after it had been for a time absent.

A Case of Rupture of the Uterus.

By P. R. BOLUS,
(Assist.-Surgeon, Royal Albert Hospital, Devonport).

A NOTE from the Editor recently reminded me that in the course of four years' work in the Falkland Islands, one of our smallest and loneliest Colonies, some unusual experiences fell to my lot. During those four years I never saw another doctor; never saw a tree, a road, or a field of corn. Gas and electricity are equally unknown, and no cable links up to the outer world the Britisher of this sub-arctic spot. A small schooner used to call once a month, if she was not wrecked on the voyage, to deliver our mail and take our news to the capital. I could explain the precise feelings of one who sits down lost in the snow at night and struggles up again just in time; I could tell you how the human frame is affected by fifteen hours in the saddle; I could set forth the humiliation of being trundled down a slope by a wild calf, or instruct you in nine and sixty ways of falling off a horse; however, space forbids, so I retaliate on the Editor by sending the following notes made while I was in the Falklands, but only unearthed from oblivion to-day.

* * * * *

Every case of spontaneous rupture of the uterus during labour, with recovery of both mother and child, is worth recording, but the following has, in addition, a mediæval savour such as is experienced in very few parts of the world in our days.

The patient was a lady of 42 years, married four years previously. The conjugate was nearly four inches. There had been one previous confinement, in October, 1904, which was also in my charge. On that occasion the child was a female, of size below the average, and the presentation left occipito anterior. The high forceps operation was necessary, and not without difficulty. One miscarriage occurred in 1905, and was efficiently treated. The pregnancy under discussion probably lasted 9½ months. It is so usual to assume a regularity in this vital function, which is found in no other, that I may be excused for noting the reasons for this statement. The history given by the patient; measurements made at the fifth and seventh months; the development of the cranial bones and nails of the fœtus; the excessive quantity of meconium in the intestine of the fœtus; the occurrence of sharp uterine pains with vaginal congestion two weeks before labour. All these things, agreeing together, suffice to establish the point. The abdomen was somewhat pendulous. Labour began late on the night of November 30th, 1907, and its course presented nothing of special interest until about 2 p.m. on De-

cember 1st. At this point patient complained of an acute pain, with a sensation of tearing when seated on a commode during a contraction.

At 2.30 p.m. the condition was as follows: Patient complained of persistent pain in the left hypochondriac region, described as being worse than the pains due to contractions. These latter occurred at three minutes' intervals. Patient who, as a rule, bore pain well, was obviously in great agony, with copious perspiration on the forehead. The pulse was 110, soon rising to 122. Bleeding from vulva slight. I now commenced administering chloroform. The os was fully patulous, and the presentation a brow. The head lay high, was movable, and was not engaged in the true pelvis. Amniotic fluid was scanty. An irregular surface was palpable on the left side of the lower uterine segment, which I explored no further than to ascertain that no intestine or omentum presented. Patient's pulse rate was rising, and her condition rapidly becoming critical. Considering the uterine rupture to be in all probability extra-peritoneal, I applied long forceps, but, as might be expected, found it impossible to bring the head into the pelvis. I next cautiously inserted a hand, with a view to performing version. I found that while the head was lying fairly free, the body and the lower limbs were so tightly gripped that turning was impossible. Pulse 140, running. Such was the position of affairs I had to face unassisted, for there was no nurse present, nor any obtainable, neither was there any possibility of getting medical assistance, since my nearest colleague was distant 120 miles by water. Moreover, with the exception of perineal needles and sutures, with one pair of Spencer Wells forceps, which had been previously sterilised in case of need, no instruments of any kind were at hand. However, as an immediate laparotomy offered the patient her only chance of life, there was no alternative but to proceed with it. So, after a hasty washing of the parts with lysol, I sent for the patient's husband, entrusted him with the chloroform mask, and borrowing his penknife, which proved to be beautifully sharp, I made a median incision of 6 inches in length, beginning some $2\frac{1}{2}$ inches above the umbilicus. My reasons for making the incision rather high were to avoid having to deal with the rupture of the uterus or disturb the adnexa. Dividing fascia, aponeurosis and peritoneum with one cut, I turned the uterus forward. Repressing the omentum and intestines which protruded above it, I had to call on the assistance of my wife to hold them in place by a pad of lint. And here I would pay her the well-earned tribute of saying that though she had never seen an operation before, her coolness and activity were invaluable. Having opened the uterus and removed child, placenta and membranes, the upper part of the wound was roughly isolated by gauze, and bleeding stopped by Spencer Wells, and I prepared to close the abdomen.

My clean ligatures seemed to have disappeared, so I had to proceed with others, unsterilised, which were at hand. Shortly, however, the clean materials came to light, under the baby, which the Scotch servant had laid in the basin of lysol that contained them. A borrowed piece of string was requisitioned to strangulate the uterus. Gentle reader, do not, if the fates provide an alternative, adopt this method. As it was impossible by this means entirely to stop the bleeding observable at the cut surface of the uterus, I proceeded no further at this time. The wound was dressed with cyanide gauze, and the projecting portion of the uterus wrapped in lint was allowed to rest on the abdomen. The portion of the uterus immediately below the string ligature was fixed in the lower end of the wound. All this was done with the utmost rapidity, and I doubt if the entire operation occupied as much as 15 minutes.

Patient's pulse at the wrist was now barely discernible; respiration shallow and irregular. The usual catalogue of restoratives, including the raising of the foot of the bed and injection of ether, was then applied vigorously. At 6 p.m. patient was still unconscious, but respiration was more satisfactory. I therefore injected $\frac{1}{4}$ gr. of morphia with 1/100 gr. of atropine in order to avoid vomiting, and reinforced my string ligature with a piece of rubber tubing. This stopped the slight hæmorrhage which had been present. During the night there was low delirium, twitching at bedclothes, shallow sighing respiration; light yellow colour of skin; and subconscious complaint of pain. I gave the gloomiest prognosis, and sat down to ponder on the chances of life holding out for hours or days. On December 2nd I found it advisable to give a few breaths of chloroform to subdue pain, and from this time till December 6th I kept the patient sufficiently under the influence of morphia to ensure rest and quiet without loss of consciousness. The amount of morphia injected was very large, and here I would impress a point sometimes neglected. Having decided that a certain effect is necessary, and that a certain drug will produce that effect, dismiss all memories of maximum doses and toxiological disasters from the mind. Starting with moderate doses, increase these continuously until either the desired effect is produced or toxic symptoms warn one to desist. In this case I attribute the patient's recovery mainly to the avoidance of shock and of intestinal movement by the heroic doses of morphia given at this period. At no time after the operation was there any vomiting; at no time, even with two-hourly feeds, was the appetite impaired; at no time was catheterisation necessary nor the desire for movement troublesome. In addition to all this, patient was relieved from the memory of a distressing time, and she afterwards had no recollection whatever of the period between the commencement of the anæsthetic on December 1st and the morning of December 6th when stimulation became urgently necessary. Through

all this period life was, as it were, hanging by a thread; indeed, the condition was so critical that I could not be confident on any evening that the patient would be alive the following morning. The external part of the uterus showed signs of infection by a gas-forming bacillus before its removal, and the sepsis of the wound was now evident. All stitches below the topmost inch of the wound gave way, and although no hæmorrhage occurred on removal of the string and rubber tubing, pus was present in the lower angle of the wound in considerable quantities. Sterilised gauze and cyanide gauze were used as dressings, all pus being carefully mopped away at each changing of them. The temperature and pulse now rose each evening, showing a moderate degree of hectic fever; and hypogastric pain was frequent. Yet, knowing that the patient enjoyed a good constitution and exceptional pluck, I ventured to hope for a successful issue. Rectal examination showed a hard swelling in Douglas's pouch and in the left broad ligament. Symptoms of irritation of the bladder made it probable that this abscess was extending downwards from the uterine rupture around which it commenced. Therefore, warm douches of 5 per cent. lysol were employed to encourage this issue. Constipation, as is always to be expected after such operations, was now very troublesome, and it is an inevitable disadvantage of morphia to encourage this. Repeated injections caused the bowels to yield. The one which in this case, as in others, I have found most useful being composed of: olive oil 4 oz., castor oil 1½ oz., eucalyptol 3 drops and turpentine ¾ oz. This should be warmed and slowly injected into the sigmoid by means of a soft oiled rubber tube and funnel.

After December 15th the wound began gradually but steadily to improve. The amount of pus diminished quickly, and the discomfort was reduced. Meanwhile, the patient continued to take food well, her spirits were revived, and the anæmia became less extreme. On December 26th a considerable quantity of pus escaped per vaginam, followed by diminishing quantities through the next fortnight. Warm lysol douches (1 in 200) were carefully given, and though the hectic fever diminished somewhat, a suspicious rigidity of the left side of the abdomen was still present. Pain now began to be felt in the left upper quadrant of the abdomen. This region was also tender, but neither tenderness nor pain extended to the line of the wound, and I was uncertain as to the cause. Eventually, a definite rounded swelling became palpable, having the following properties:—rounded border definite above and on the median side, ill-defined below and to the left. The upper boundary extended for four inches parallel to the costal margin, and half an inch below it. The inner border ran vertically downward for about three inches at two finger breadths outside the middle line. The swelling lay behind the colon. Its consistency was firm, but elastic, and strong pulsation was felt in it. Whether the impulse was expansile or transmitted was doubtful. Besides causing local discomfort and pain on movement, a pain was felt some three inches below the swelling, most marked midway between the umbilicus and the left anterior superior iliac spine. One could then be tolerably certain that we had here a collection of fluid, encysted, probably non-purulent, unconnected either with the wound or with the interior of the intestine, and causing no symptoms except such as might be accounted for by its mechanical pressure on surrounding parts. It will be noticed that its size and position might equally well agree with a diagnosis, among others, of (1) hæmorrhagic peritoneal cyst; (2) pancreatic cyst; (3) abdominal aneurysm; and (4) peritonitis with effusion of the lesser sac. (2) was excluded because no previous intestinal symptoms occurred, and the stools were normal. (4) was rendered daily more improbable, as the swelling continued firm and increased slightly in size, but did not extend further towards the right side than it had done when first noticed. After persisting for three weeks the fluid gradually diminished, and in the course of two months this mysterious tumour entirely disappeared, leaving no thickening or palpable sign.

I leave it to wiser folk to suggest what it was. The patient made a slow but very perfect recovery; was able within the year to ride fifty miles a day, and regained all her previous health and vigour.

The child suffered from slight anasarca from birth, and lived for only three months.

Pupils' Physical Society.

THE fourth meeting of the present session—a clinical evening—was held in the Wills Library on Saturday, November 12th. Mr. Bromley was in the chair and thirty-seven members were present. The following cases were shown:—

1. Scurvy, by Mr. Neville Cox
2. Acromegaly, by Mr. Cline.
3. Erbs' Paralysis, by Mr. Perceval.
4 & 5. Two Cases of Cretinism, by Dr. Mann.
6. Kala Azar, by Mr. Pochin.
7. Pyo-pneumothorax, by Mr. Godding.
8. Porridge-fed Baby, by Dr. Mann.
9. Juvenile Tabes, with Optic Atrophy, by Mr. Carruthers.
10. Epilepsy, with Visual Hallucinations, by Dr. Mann.
11. Infantile Ataxia, by Dr. Mann.

The following also contributed to the discussion:—Messrs. Warner, Mutch, Cook, Bennett, Marshall, Doll, Sandison, Maxted, and the Honorary Secretaries.

The Treatment of Pneumonia.

CLINICAL LECTURE BY DR. HALE WHITE.

GENTLEMEN,—You see so many cases of pneumonia in the hospital, and you will see so many when you get out into the world afterwards, that you will often have the opportunity of considering the best way of treating them. When you have discovered that your patient has pneumonia, the first thing you have to do is to put him to bed. You will remember that when we spoke of typhoid fever we discussed why a patient should go to bed. I told you that, even if all the rise of temperature in a fever was due to increased production of heat, there would be only about 55 large calories of heat necessary to raise a man's temperature one degree; so that the number of calories necessary to send his temperature up four or five degrees would not be very many. One reason, no doubt, for giving him rest in bed is to give him less work to do, because he has to do the work of raising his own temperature, although some of the rise may be due to diminished loss of heat. But probably a more powerful reason is that the micro-organisms of pneumonia manufacture a poison which is peculiarly pernicious to the heart, and it is because of this that the sufferer ought to go to bed and rest the heart. The heart cannot do the work which it would have to do if he were up and about and had pneumonia at the same time. When a man with pneumonia dies, he genrally dies from his heart. Patients who have had pneumonia may get up from bed earlier than the patients with some other fevers. The extreme fatigue of the fever passes off quicker after pneumonia than it does after diphtheria or typhoid, for example; so that if the temperature has been normal for a week you may generally safely get the patient up. The bed should be narrow. It is difficult to nurse patients in a big bed, and nothing could be worse than trying to nurse them in the old-fashioned four-poster feather bed. The patient should be in a large room, with a temperature of about 60 degrees, with open windows, if possible, and therefore it is desirable to have a fire going, except in the summer. You should not let the patient get up for any purpose, and therefore the bed-pan should be used.

With regard to food, this is important, but it is not nearly so important as it was seen to be in the case of typhoid fever. The reasons are, firstly, pneumonia is a short fever; the crisis often occurs at the end of a week, or even earlier; and, secondly, there is no intestinal ulceration to make the feeding more difficult. So, as pneumonia is a short fever, it does not matter much if the patient lives on milk alone. I told you, in speaking of typhoid fever, that three pints of milk contain only 975 calories of energy, and that taken daily is semi-starvation diet; a man wants 2,000 calories, even when he is lying in bed. Still, for the short duration of pneumonia, three pints of good milk a day will usually suffice. Those with fever are very thirsty, and so they want fluid, and as their mouths are very dry they can only swallow fluid. Next, they want easily-digested food, and milk is that. So on all grounds milk is desirable. But these patients are so thirsty that three pints of milk do not supply enough fluid, so you will supplement it by barley water, lemonade, etc. Though pneumonia patients complain of the disagreeableness of milk, they do not find it so monotonous as do typhoid fever patients, because the disease is shorter. But you can flavour the milk with black coffee, or vanilla, or tea. It is customary to give these patients beef tea and beef extracts. The nourishment in these is very little, and there is no harm in having them if the patient likes. But I think many patients suffering from pneumonia have too much of beef essences, and the system is flooded with them unnecessarily. If the patient feels he is not getting enough food, you can give him bread and milk, or custard, or egg beaten up in his milk. Very often these patients get a dry sore mouth, and for which you can use the same mouth washes as I mentioned in connection with typhoid. One is 1 in 500 of formalin, which may be flavoured with tincture of myrrh or glycerine. Another wash is 15 drops of glycerine of carbolic acid to 1 oz. of water. Most pneumonia patients are constipated; it is a common practice to give them colocynth and hyoscyamus pill.

The next point there is much discussion about, namely, shall you put any local application on the chest? I do not know that any local application on the chest has an effect on the pneumonic process; but, usually speaking, there is some pleurisy associated with the pneumonia; consequently the patient has pain, which may keep him awake at night. This pain may be very severe, and local applications will be of great help. You can stop the pain by either extreme heat or extreme cold, and my experience is that an equal number of people prefer hot to those who like cold applications. I remember

one of our own students having pneumonia, and he had no doubt whatever that cold was the best application to relieve his pain. To make an ice poultice for the chest, take powdered ice and put it on a layer of wool which lies on some gutta-percha tissue, and to the ice you add a little salt. Turn the edges of the gutta-percha over this mixture, seal the edges with turpentine, and put the whole into a flannel bag, and fasten it on to the chest. If that does not relieve the pain put on an ordinary linseed poultice. The mistake which is generally made is to put on too heavy an application. If the pain does not need it, do not put on any local application at all, because the weight of the application makes breathing difficult, owing to the disease of the lung. That is peculiarly the case with children, as they are not strong enough to lift a heavy poultice with their breathing. Try it on your own chest, and reflect how much influence it must have on a child who has pneumonia.

Now we come to the question of drugs. Unfortunately, there is no specific for pneumonia. But please do not have the impression which so many superficial people have, that because there is no specific for the disease the treatment does not matter. As I said in connection with typhoid fever, let the patients treat themselves, and you will soon see how the mortality will rise. Although there is no specific treatment, you can do much by drugs. Do not give the so-called expectorants, ipecacuanha, senega, squill, etc. All those are emetics, and many of them are powerful cardiac depressants. And yet you propose to give a man a drug which, at the best, has only the reputation of enabling him to cough more, but may make him sick and depress his heart. Of drugs the most good comes from opium. It relieves the pain and gets the patient to sleep. Remember that a pneumonia patient, if he is going to die, will die from cardiac failure. Look at the amount of rest to the heart which is obtained by eight hours sleep; it is enormous. So give 10 or 15 grains of Dover's powder at night if the sufferer does not sleep well. You will find in some books that opium is a powerful respiratory depressant, and, therefore, is bad for a man with disease of the respiratory organs. That is wrong, at any rate for pneumonia, which does not usually kill from its effect on the lung. All experience shows the patient is much better after a quiet night, and unless he is obviously in danger from depression of respiration, you may safely give the Dover's powder.

The general restlessness, sleeplessness, and delirium in pneumonia are often a great trouble, especially in alcoholic patients. Every year alcoholic patients who have pneumonia have to be transferred to the strong room because of noisy restless delirium. Opium does not seem to suit them quite so well as it does the other patients. When they are very bad and you feel they must be kept quiet at once or you may lose them, give $\frac{1}{100}$th of a grain of hyoscine subcutaneously. I do not think you will do harm by that, and it is an excellent drug to calm the patient. But it is a very powerful poison, so powerful that everyone has been rightly taught to use it with great care. Unless a case is desperate, I do not care to use it. I prefer a strong dose of paraldehyde. You will find that is an excellent hypnotic for the cases in which there is much delirium. You can give two drams for an adult. It is difficult to prescribe, because it is heavy and mixes badly. The best way is to put two drams of paraldehyde in four ounces of water, flavour it with syrup of orange, and tell the patient to gulp it down at once. It does not make the patient sick when once it is down. If for any reason you do not care to give this, I do not mind which you give of chloralamide, trional, or sulphonal. I generally give 20 to 30 grains of the first of these, because, dissolved in brandy, it makes a nice way of giving the patient something to send him to sleep. The nurse may tell you she cannot dissolve it, but that is because she has not stirred it long enough. The water should not be added too hot, or it may, perhaps, decompose the chloralamide. If you do not care to do that, use trional or sulphonal. The drug I do not want you to use is veronal. It is very popular, and is being largely used, but I have seen one fatal case, and one nearly fatal, although in both small doses were given; and I have heard of others. As there are other drugs for the purpose, it is not desirable to give one which has been known to cause such results. I have known 10 grains of veronal kill a man outright.

If the temperature is very high, 105° or 106°, often the delirium and restlessness of pneumonia will be much lessened if you sponge the patient, and in that way bring the temperature down two or three degrees.

As you know, alcohol has many advantages. The heat value of an ounce of alcohol is 200 calories. Therefore, inasmuch as in most brandy there are equal parts of alcohol and water, the heat value of one ounce of brandy is 100 calories. So it is a very good food, and, as I said in talking of typhoid, if some one could abstract from the alcohol all the deleterious part, and leave us with the other, it would be one of the best foods

imaginable, because it requires no digestion and is absorbed as such and utilized straightway by the body. Some years ago it was the fashion to give large quantities. I have seen a pint of brandy a day given for pneumonia. Nowadays, I think, we sometimes give too little in bad cases of pneumonia. I cannot give you a rule as to when to give it, but you can try it and see if it does the patient good. If it is going to do him good it will make him sleep, it will help his digestion, it will tend to strengthen and slightly slow the pulse. All that is very good. But with some people it causes excitement, and the patient does not sleep. His pulse is made more rapid, and he gets more nervous. To such a patient you must not give it more than once. Some patients will tell you that they sleep very well at night if they take spirit and water before going to bed. Others will lie awake if they take it. If the patient can take it, you may give 5 ounces of brandy in twenty-four hours. If it is slowing the pulse, you are thereby giving a valuable food.

I have mentioned that if a man is going to die from pneumonia he will probably die from failure of the heart. That leads me to point out that it is the pulse which is of great value for estimating the outlook in pneumonia. If the pulse is constantly mounting in rate the patient is doing badly, and frequently you will wish to strengthen and slow the pulse. For that there is no better drug than digitalis. The mixture which I have often used in the wards is 15 mm. tincture of digitalis, 10 mm. liquor strychninæ, with 5 grs. of caffein, and 2½ of salicylate of sodium to dissolve the caffein. This with water makes a very good mixture given every four hours, or you can give digitaline subcutaneously. If you give the amorphous variety, the dose is $\frac{1}{100}$th of a grain; if the crystalline, $\frac{1}{130}$th of a grain. I am not very fond of giving digitalin, because, like hyoscine, it is a powerful poison, and the mixture just mentioned seems to act well. Personally, I have a great belief in the value of strychnine subcutaneously in pneumonia. I have given strychnine, 10 mm. of the liquor subcutaneously every four hours, even until the patient has twitched, then, of course, it is stopped. The patient appears to be made better by the strychnine, both as regards the heart and the respiration. Of course, I cannot absolutely prove it to you, I can only give you my strong impression, and that is that many bad cases of pneumonia can just be tided over the critical point by giving them plenty of strychnine subcutaneously. One advantage of it over digitalis is that it is a respiratory stimulant, which digitalis is not; it does not cause nausea and sickness, which digitalis may; and digitalis, if it is going to poison the patient, may do it suddenly, as it has a cumulative effect. But I have never seen harm result from strychnine, if the patient is carefully watched, and it is stopped at the first sign of twitching. Adrenalin we were using two or three years ago in Clinical, and it does resuscitate the pulse and increase the blood-pressure in some cases. We used to inject 10 mm. of 1 in 1000 solution of adrenalin chloride. The great disadvantage is, the improvement is so temporary; it only lasts a few minutes in many cases. Pituitary extract is a much better drug, because the improved blood-pressure lasts longer. You can inject 1 c.c., and it is said that it should be injected deep into the muscles. I have injected it subcutaneously, and no harm has resulted. If the patient is dying, you must not expect to see the blood-pressure raised, because in the case of all drugs there must be a point at which the patient is so ill that no effect occurs. The other day we gave a man pituitary extract in John ward, and it made no difference. He was very ill, and should have come in 48 hours earlier. I have never known any harm result from the use of it, and it is said that you do not get long-standing benefit if you give repeated injections of it. But, at any rate, you can save a patient's life with it when it is a question of keeping him going a few hours until the crisis. A few months ago I had to meet a doctor about a case of pneumonia; he was prevented from meeting me, but left word with the nurse that he was afraid it did not matter, for the patient would certainly die. It was about 10 p.m. Pituitary extract was given, and repeated at 2 a.m. The patient struggled through the night, and is now well. Never give up a pneumonia case; you can never tell when the crisis is coming. I remember a woman who was seen by a distinguished physician, and he said it would be quite unnecessary for him to come again as she was so ill. He never saw her again until he met her in the street one day, quite well. The crisis occurred a quarter of an hour after he left the house.

Often sufferers from pneumonia are benefited by the use of oxygen, and I do not know that that can do any harm. I have often, I think, seen it do good. I remember an intelligent man who was very ill indeed with pneumonia and had oxygen given him frequently, and he said, "That stuff you gave me to inhale made me feel as if I had had a glass of champagne." He was too ill at the time to tell us much about

his feelings, he told us afterwards. Often the oxygen is very badly given indeed, the nurse simply waves the end of the oxygen tube somewhere near the patient once in every few minutes. That is a waste of oxygen; in most cases not nearly enough is given. If you go into the ward at the present time you will see the funnel pinned to the bedclothes, quite close to the patient's mouth, so that with every respiration he must be taking in some oxygen. Professor Leonard Hill has devised a chamber by which patients can be shut in with the oxygen. I do not know whether we shall often have the opportunity of using such a chamber as that, but it shows how impressed he is with the foolishness of the way in which oxygen is often given. The oxygen should be warmed, before it is inhaled, by letting a few of the coils of the rubber tube lie in warm water, because liberated suddenly from the cylinder it cools rapidly. Some people have the gas passed through water, so that when it reaches the patient it is moist as well as warm when it reaches the lungs. I am now trying the proposal to let it bubble through absolute alcohol.

Occasionally the pneumonia patient is livid. In such a case the benefit you will confer by bleeding is very great indeed. What one supposes has happened is, that the exudation in the lungs is so great that the right heart has been unable to pump the blood properly through them, and hence the blood has collected in the venous side of the circulation, and the right heart is distended. It is, as you know, hopeless to deal with a distended bladder until you have emptied it with a catheter. In the same way, you should deal with the engorged right side of the heart by taking away some blood from a vein. For an adult, ten ounces is a good average amount, but it depends a good deal on the degree of lividity, and on the pulse. Always bleed the patient in the sitting-up posture, so that when he feels faint you can stop. If he is lying down when you do it, you may take away so much as to cause him to faint.

In pneumonia, within certain limits, a raised temperature is a good thing, as I have often told you. Collections of cases have shown that if you put them into groups, 104 to 105, 103 to 104, 102 to 103, 101 to 102, 100 to 101, 99 to 100, the groups in which the temperature is lower do worse than those in whom the temperature is higher. Since I have had charge of Clinical this winter, we had a case of pneumonia in which the man's temperature was normal, or if raised at all, not more than one degree. He always seemed very ill, and after three days died. So you need not often be anxious to bring down the temperature in pneumonia, because the patient is usually doing well in proportion to the raising of the temperature. If, however, it reaches 105 or 106, sponge until you bring it down to 103; but that is not often necessary. Some cases you may find are doing badly because the temperature is too low. Then you will do all you can to raise it, by the application of hot-water bottles and blankets. But when the temperature is so low that you have to do this, the chances are that you will not save the patient.

There remains the point as to whether there is any specific treatment. Some years ago, after the glamour of the discovery of serum treatment of diphtheria, people tried to find a serum for the treatment of pneumonia, and donkeys, and other animals, were inoculated with human pneumococci, and repeatedly inoculated, just as for diphtheria. After these inoculations, the number of anti-bodies in the serum is increased, and after some time the animal is bled, and the serum from its blood is antitoxic. But, unfortunately, this serum has not been of much use for pneumonia. Dr. Washbourne was very anxious to discover a serum for pneumonia, and I have seen several cases treated by a serum he prepared in this way, but it failed to do good. Nor are the reasons far to seek. Firstly, the pneumococcus varies so very much in different strains that you ought, for each case, to have a serum prepared from the micro-organisms of that case, but it is clear that if you are going to take the pneumococci from a patient, and repeatedly inject them into a donkey, and keep that donkey for a long while before the serum is ready, your patient will hardly want treatment by it. Another reason why the serum is not of use is that the patient is quickly ill with toxæmia quite early in the case, so that what you want is a powerful antitoxic serum, but this has not yet been made, and with regard to sera which are bactericidal, those hitherto prepared are not sufficiently strong in this direction.

Of course, vaccines have also been tried, but here, again, there is the difficulty caused by the different strains, so that a stock vaccine is not likely to be much good. You see pneumococcal vaccines used, but they are beneficial only in the chronic cases, such as when there are empyæmata, or pneumococcal enteritis, or pneumococcal disease of the joints. For those you can cultivate the pneumococci from the patient and make a vaccine, and often give it with much

benefit. In pneumonia the crisis is often near at hand before a vaccine can be prepared.

I have nothing special to tell you about convalescence from the disease. Patients recover very quickly compared with those with typhoid. The latter cannot return to work under three months after getting up from bed; the disease pulls the patient down so. The pneumonia patient can return to work a month after getting up.

The Magic of Morphia Hypodermica.

Faced with a patient having fits other than hysterical (when cold water and smacking are generally successful), when nothing can be got down the throat, and rectal medication is almost impossible or uncertain, use morphia hypodermically, whatever the age (except infants) and whatever the cause, and regardless of what the books say.

I can remember a middle-aged man with albuminuria (granular kidney) and uræmic convulsions in whose case one morphia H.I. stopped the fits and saved the life.

A young woman having fits on the eve of a first confinement—one morphia H.I.—no more fits and a safe delivery.

There will not be success in every case, but it may save life, and does no harm.

A boy, now aged 12, has had fits off and on since he was 8½ years old. He had been fifteen months without any. In June this year they began again. Though of short duration, they are strong enough to make him fall, and there are strong tonic and clonic spasms while they last, with micturition very often. In the days preceding August 26th he had had fits in bed almost incessantly—about 200. He was so weak that he could not sit up in bed nor extend his arms or fingers. At this juncture I gave morphine, $\frac{5}{12}$ gr., with atropine, $\frac{1}{120}$ gr. The fit after this was weaker, and afterwards he had a few *petit mal* attacks without movement of the limbs. He has gone on daily gaining strength, without any more fits, though at first he had synovitis of one knee-joint from kicking in his fits, and all his muscles were paralysed with exhaustion. To-day, September 26th, he is running about and swinging in the garden, and able take good walks in the country. A consultant who saw the child with me the day after I had given the hypodermic told the mother I had saved the child's life.

Why is it that, when the effect of the injection has passed off, the fits do not return? What is the chemico-pathological explanation?

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"AFTER THIRTY YEARS."

Universal Military Training.

A debate on the above subject was held under the joint auspices of the National Service League and the Guy's Hospital Students' Club, on November 10th, in the College Smoke-room.

Dr. HALE WHITE occupied the chair, and there was a large attendance of members.

Col. R. NUGENT, C.B., in moving the resolution that "In the opinion of this House, Universal Military Training for Home Defence is necessary for the safety and welfare of Great Britain, and for the peace of the world," opened with an outline of Lord Roberts' proposals. It is suggested that all schoolboys and lads between the ages of 12 and 18 shall be instructed in graduated drills and musketry training, and that everyone, irrespective of wealth and position, who is physically able, shall serve in the ranks for not less than a period of four continuous months on arriving at the age of 18; and that from 19 to 22 all shall belong to the Territorial Force as at present organised, with the sole exception that no commissions should be given except to those who had undergone the full previous training as privates and N.C.O.'s. Between 22 and 30 years of age there would be no further parades and drills, but they would be liable to be called out in a national emergency, so declared by Parliament, for home defence. Unless he volunteered, no member could be ordered overseas. Col. Nugent dwelt on the small amount of interference with the existing military organisation and with industrial and commercial pursuits which this would entail, and the democratic nature of the scheme, which, he urged, would tend to diminish class prejudices besides improving the morale and physique of the nation. He pointed out, too, that it would give the loafers of every class, irrespective of their means and condition, the discipline they all require. He contended that the money it would cost—£3,800,000 a year—would diminish unemployment, and certainly should be regarded as productive labour, seeing that it formed character and built up health and muscle and energy, and was no more a waste of time and expenditure than what was incurred when works were closed for overhaul and repair. He quoted extracts from the works and writings of Burke, John Stuart Mill, Carlyle and Gladstone to show the adhesion of these great authorities to the principles of universal military training, and reminded his hearers that the Territorial Force could not be called out to quell civil disturbances, showing conclusively that all free men had everything to gain and nothing to fear in respect of national and individual liberty.

Mr. RYLE said: There are several main points of view from which it is desirable to attack this colossal absurdity—the compulsory idea. They are the biological, moral, economical, and religious points of view, and the point of view of the practical idealist. These must be dealt with in the first place. In the second place we must enter into a consideration of the question of war, for it is on the probability or otherwise, the necessity or

otherwise, and the effectuality or otherwise of wars in the future that the whole discussion depends.

Biological aspect.—The hon. proposer and others have committed a tremendous fallacy in stating that military service favours racial development. Militarism is, has been, and always will be, one of the most potent factors of race degeneracy. Here we have a system whereby the fit are removed from society, and rendered at once unproductive and unreproductive, and, in the event of a war, are killed or maimed, while the unfit multiply merrily. Even if four months in the year is not so bad as continual service, it is sufficient to render training for a trade impossible, and employment irregular. Another important consideration is that of the effects of herding large numbers of men together under unnatural conditions. The results are various forms of degeneracy, and the maintenance of a high percentage of sufferers from venereal diseases. Further, it is not only physique that suffers. Neither men nor officers in the Army are noted for their intellectual attainments.

Moral aspect.—In the first place, compulsion is always an evil, being opposed to all the principles of liberty and justice. The objection may be made that we are, for instance, compelled to pay taxes. True, but taxes are at present an economic necessity, whereas militarism is directly opposed to all economic advancement. In regard to the question of discipline the position of the proposer is untenable. Discipline, in the military sense, means nothing more than the conversion of men into a host of mechanical sheep. Men and officers alike become entirely dependent beings. Submission to the authority of men of another class is also undesirable. Compulsion has just as bad effects on society, and unrest and revolutions are apt to result from the enforcement of such systems.

Economic aspect. First of all there is the direct expenditure that is necessitated. The Army already costs the nation twenty-seven and a half millions per annum; and we must remember that this expenditure is entirely unproductive. There is, in fact, a direct loss of work proportioned to the size of the Army. It is iniquitous that we should propose to spend more on military defence, when there is already such a crying need for social reform, for defence from an internal foe. This ridiculous game of international tit-for-tat cannot go on for ever. In the words of Mr. Asquith, a vicious circle has been set up. Armaments are increased because nations are afraid, and nations are afraid because armaments are increased.

Religious aspect. It is one of the most distressing features of the movement that the clergy and women are giving it such vigorous support. That the servants of the Prince of Peace should encourage the community to learn the ways of war, is as sad as it is incomprehensible. Bright, in his speech on Peace before the Russian war, made an appeal from the religious point of view: "Is this a reality?" he said, referring to the national faith, "or is your Christianity a romance? Is your profession a romance; and I am equally sure that your profession is not a dream. . . . I believe that we shall see . . . . sound economic principles spreading much more widely amongst the people, a sense of justice growing up in a soil hitherto deemed unfruitful, and . . . . a time when nation shall not lift up sword against nation, neither shall they learn war any more."

There is, gentlemen, such a thing as a Practical Idealism, and Peace and Disarmament are within the bounds of this. We boast our civilization today, but are somewhat in danger of reverting to the methods of barbarism. Governments deplore the need for armaments, but go on spending. The organs of the Press boom war and militarism, for it is for their profit. Capitalists urge them, for they are the only people who are likely to reap a harvest. What wonder that some of the masses are sucked into the stream? But democracy is not dead, and compulsory service is anathema to democracy.

Now, gentlemen, I wish you to consider the question of war and to obtain an idea of its futility from the economic aspect. In ancient times conquest meant a tangible advantage, in the way of loot, or exploitation of territory. Later, wars were the struggles of sovereigns for prestige. Later still, they were for the substitution of order for disorder. None of these conditions is part of of our problem. Nowadays nations are economically absolutely interdependent; and if, as has been suggested, Germany captured London, any upset of English credit would promptly be felt in Berlin. English trade could not be destroyed unless the population were destroyed. That "International good faith is a better defence than armaments" is shown by the fact that the smaller countries are financially far more secure. Whereas powerless Belgium's 3 per cents. are quoted at 96, powerful Germany's 3 per cents. are only quoted at 82, and this rule holds good throughout. Denmark has actually considered the abolition of her Army and Navy. Seeing, then, that those nations are most secure which are most free from the provocative taint of militarism, the only logical course is to oppose rather than to encourage an increase in armaments throughout the world.

Finally, gentlemen, be not led away by appeals which, however stirring they may seem, are really infantile in the lack of forethought they display. The bugle and the drum have a fascination for us which dates from early days, but the music that emanates from them is not conducive to quiet thought or sensible reflections. As makers of to-morrow we have a great responsibility, and, knowing that we hold this responsibility, I feel that you will not rashly support proposals for a system that is so entirely antagonistic to all our ideas and ideals of civilization.

Mr. LUCEY seconded the motion, and Mr. M. SCOTT the opposition.

The following also spoke in the discussion: Messrs. Sandison, Layton, Neft, Nealy and Cook, and Capt. Herringham.

Col. Nugent, in reply to other speakers, admitted that a military career did not tend to produce able writers or good talkers and debaters, but that the short open-air training advocated by Lord Roberts would have none of the deadening effects of a military life in respect of the intellect and moral perceptions. He instanced that in the Admiralty Courts clever solicitors and glib barristers easily made out that pilots, masters of vessels and mariners knew far less of their work than those who wrote at their desks or spoke in the Courts. All the same, would any of his hearers go to sea in a yacht or ship manned by men of the Law in preference to the man of action and experience? He good-naturedly rebuked those, too, who were inclined to underrate what they termed the military mind. As regards conscientious objectors, he knew some members of the Society of Friends, and they told him they would certainly defend their houses if attacked by burglars and also come to the rescue of their neighbours in a similar plight. How, then, would it be wrong for them to combine and train for the protection of a collection of houses? This citizen Army was for home defence only—no menace to any Power unless it invaded us—and moreover, anyone who wished could serve in the medical or other non-combatant branches.

The Chairman then put the motion to the meeting, and there voted:—In favour, 42; against, 26. The motion was therefore declared carried.

Votes of thanks to Col. Nugent and Dr. Hale White concluded the meeting.

Pass List.

University of London.

Third (M.B., B.S.) Examination for Medical Degrees, October, 1910.

Pass.

A. Neville Cox.	R. Montgomery.
F. A. Dick.	G. T. Mullally.
G. Dunderdale.	H. F. Renton.
A. H. Gool.	R. Stout.
W. S. Kidd.	G. Y. Thomson.
A. E. Lees.	A. D. Vazquez.

Supplementary Pass List.

The following Candidates have passed in one of the two groups of subjects:—

Group I.—(Medicine).

W. E. Fox. | J. T. Montgomery McDougall.

Group II.—(Surgery and Midwifery).

M. M. Cowasjee. | J. A. Edmond.

E. A. Penny.

Final Conjoint Examination, Nov., 1910.

G. B. Cockrem.	H. F. Renton.
*W. E. Fox.	W. Reynolds, L.D.S. Eng.
W. H. Talfourd Jones.	Q. H. Richards.
C. D. Killpack.	G. Y. Thomson.
R. Montgomery.	

* Diploma of M.R.C.S. conferred on October 13th.

Royal College of Surgeons of England. November, 1910.

First Examination for the Fellowship.

C. C. Holman, M.B., B.C.

LICENCE IN DENTAL SURGERY.

First Professional Examination.—Mechanical Dentistry and Dental Metallurgy.

A. D. Buck.	H. B. Neely.
*A. J. Chapman.	*R. Neft.
†H. G. Elliott.	I. W. Pasmore.
†W. T. Flooks.	*P. J. Peatfield.
†W. H. Glover.	†G. L. Pemberton.
*C. Glover.	*C. J. Phillips.
J. H. H. Griffin.	L. R. Pickett.
T. E. Henderson,	*J. H. Ross.
M. F. Hopson.	†A. F. Salsbury.
*C. H. Housden.	M. Schneider.
†Huckett, E. S.	F. B. Stradling.
*L. T. Montgomery.	W. S. Stranack.
D. B. Morrish.	T. B. Tustian.

†F. Wisher.

* Mechanical Dentistry only. † Dental Metallurgy only.

Final Examination for the Licence in Dental Surgery, November, 1910.

Parts I. and II.

*A. P. L. Johnson.	*P. B. Stoner.
*Stanley Morgan.	*E. S. Tait.

Part I. only.

J. Benson.	G. Matthews.
R. B. Campion.	H. L. Messenger.
F. H. Edey.	W. S. Ollis.
W. H. Edmonds.	F. W. Paul.
F. A. Jaques.	H. T. Peplow.
W. S. Lakeman.	A. E. V. Spill.
A. P. Marsh.	O. B. Townsend.

J. H. Wiles.

Part II. only.

*H. F. Barge.	*Stanley Lawson.
*C. H. Barnett.	*C. H. G. Penny.
*R. N. Curnow.	*C. E. Rice.
*F. S. Glover.	*G. E. Rowstron.
*C. J. Henry.	*A. T. Rycroft
*W. J. Kennealy.	*W. H. Wotton.
*E. A. C. Knox-Davies.	*E. O. Yerbury.

* Denotes completion of examination.

Periodicals Received.—The Hospital; The Clinical Journal; The Nursing Times; The Calcutta Medical Journal; Le Mois Médical; The Manchester University Magazine; The Polyclinic; The Prescriber; London Hospital Gazette; The Middlesex Hospital Journal; St. Thomas's Hospital Gazette; St. Bartholomew's Hospital Journal; St. George's Hospital Gazette; The MS. Journal; New York State Journal of Medicine; The Gambolier.

The Importance of Mrs. Gamp.

THERE is at present a Bill before Parliament, called the Midwives (No. 2) Bill, one of the clauses of which makes the provision that if a midwife who is attending a parturient woman finds it necessary to send for medical aid she must do so whether her patient can or cannot afford to pay the medical practitioner who arrives in answer to that summons; and, further, this clause, the seventeenth, states that in the event of the patient being unable to pay the doctor's fee, that fee shall be made chargeable to the local Board of Guardians. The reason for Clause 17 is evident. It was called forth by the difficulty which often confronted the general practitioner, due to the absence of some secure expectation of payment. Some medical men had even found it necessary to refuse to attend unless their fees were paid beforehand. A Departmental Committee was therefore required to look into the matter, which was rapidly becoming a crying evil, and it came to the conclusion that some intervention by the State was necessary to assure the payment of the fee if it could not be obtained from the patient or her relatives. By the advice of the Local Government Board this responsibility was placed on the Boards of Guardians, with the special concession that such payment of fees was not to be considered as a ground for any pauper disqualification. This Bill has already passed through the House of Lords, where it originated, and will appear for discussion before the House of Commons sometime during the coming session. Now, as there are a large number of Guy's men in general practice, and as Clause 17 of the Bill will tend, in our opinion, to work disastrously against them in their practice, it becomes necessary and is a sufficient excuse to deal in the GAZETTE with the chief reason for opposing that clause.

There has been some correspondence in the Press lately as to whether it is right and proper that the Board of Guardians or the Public Health Authority should pay the fee in question, but it is not the purpose of this article to undertake such an inquiry. Suffice it to say that there are some people who maintain that the Board of Guardians, representing as it does the Poor Law, is wholly and absolutely detested by the poor (as all law is, as a matter of fact, by those whom it may concern), and that, therefore, the patient and her midwife will neglect the law and take the consequences rather than send for the doctor and face the relieving officer—a course of action which is perfectly understandable. But the people who hold this opinion believe that such a procedure is harmful both to the mother and to her babe, and to the community of which they form a part, and ought not, therefore, to be encouraged. Others assert that if a poor woman does apply to the public funds for assistance, she cannot be, nor ought she to be, so fastidious as to wish to elect at whose hands she shall receive the payment; that, in fact, it is an old and a wise economic principle that beggars should not be choosers. Further, the people who hold this opinion believe, and quite rightly, too, we think, that the "principle of deterrence" involved in the existing machinery of the Poor Law would prevent, and effectively prevent, the richer members of the community, who could afford to pay their own medical attendant, from relying too entirely upon the benevolence of the public funds. However, as we have already declared, it is not the purpose of this article to enter into the discussion of, nor to inquire into, which is the more moral of the principles involved. Such a question is primarily one for our legislators, and for what is known as "public opinion." It only becomes a question for the medical man when he is considering his position as a ratepayer of the community. From the purely professional and non-party point of view it matters nothing to him as to who pays him his fee, and the issue which has divided public opinion upon Clause 17 of the Bill should give him little concern.

But Clause 17 becomes more important to the general practitioner when he considers the fact that it really involves the principle of that completely futile proceeding of placing the cart before the horse when Hodge wants to get to town. Progress, of course, in such an eventuality is absolutely nil, and the public utility is scarcely benefited. When public opinion has settled the question as to who shall have the privilege of paying the medical practitioner his fee, there will still remain the fact that the midwife shall determine as to whether she shall have the medical practitioner or not, and, what is more important, as to who the medical practitioner shall be.

In the days before Clause 17 was thought of, in the days before it became necessary to have to pay the practising obstetrician out of public funds, the only question of practical politics being as to which public body shall sign the cheque, a woman when she became pregnant consulted her family physician, who advised her as to how she should proceed in her pregnancy; and when her hour was come it was he who named the midwife, and it was he who gave the instruction that he was to be summoned when any untoward or dangerous complication arose in the progress of that purely physiological process. But now, with the coming of Clause 17, the older order has changed, and Mrs. Gamp is paramount. It is she who will be consulted by the newly-pregnant woman; it is she who will advise the conduct and the management of the pregnancy, and when labour has begun, it is she who will name the doctor if any untoward or dangerous complication should arise. It is not here maintained that the general practitioner has anything to fear from Mrs. Gamp as Mrs. Gamp,

especially in her modern cap and apron, and with her name upon a register; but Mrs. Gamp as the General Practitioner is a totally different phenomenon, if not in herself a serious complication, and it behoves every general practitioner to ask himself if such is not the fear in store for him if he should consent to the principle laid down in Clause 17 of the Midwives Bill.

It will be stated, of course, that such a principle is not introduced for the first time in the Bill now before Parliament, that it has always been tacitly agreed to by the Medical Profession, and that the public has generally understood that a pregnant woman may, if she should so wish, consult a certified midwife during pregnancy, and engage her, and her alone, to attend her in her labour. But, as it has also been the law of the land that the midwife so engaged shall call in a medical man if any complication should arise, or forfeit her right to practise, the majority of pregnant women did not run the risk of engaging a midwife first, and then paying the doctor's fee when he was called in at the last moment, but in the majority of instances they took the precaution of consulting a doctor first, and then with his advice, and if they could afford it, of engaging the midwife during the labour and the puerperium, the practitioner acting all the time as supervisor and consultant. Clause 17, however, will change these relations between midwife and doctor. The midwife will, in the future, become the general supervisor, and the general practitioner will be merely the medical attendant. For it must be remembered that the essential part of Clause 17 is not whether the Poor Law or the Public Health Authority shall pay the doctor's fee, but that this fee shall be paid out of the public funds and not by the patient or her relatives. (The fact that such fees may be recovered summarily as a civil debt from the person or persons liable to provide the patient with medical aid does not affect the main trend of the argument here pursued, for that, after all, is a minor point of administration which may or may not be enforced according to the circumstances of the case, and the temper of the authorities concerned.) Now the policy of the public payment of such fees is not here disputed. We only wish to note very carefully its general acceptance. The fact that both of the two great bodies of public opinion above cited agree upon this point is sufficient to prove that it is considered absolutely necessary. Even the House of Lords recognised the need, although it declared in favour of the principle of deterrence for the reasons already given. So that we may record, with pleasure, perhaps, that the justice of the principle involved in the public payment of the doctor's fees under such circumstances is beyond dispute, that the need is fully recognised and accepted, and that the policy has come to stay. And yet Clause 17 will do the great body of general practitioners a grievous wrong. For, in future, every pregnant woman, because it is cheaper, will forsake the general practitioner for the certified midwife, knowing full well that if in the event of any emergency she is compelled to call in a doctor, she can do so without any further cost to herself, and at the expense of the public funds. The fact that the assistance is given through the Poor Law or the Public Health Authority can and will matter nothing to the woman in her extremity. Moreover, prejudice is usually the outcome of custom, and custom is merely a matter of what is commonly called "fashion," and, as everybody knows, the most fashionable thing in all the world is the art of saving money. Everybody endeavours to practise that art, even your "lady of fashion." So that, and more especially so when, as in this Bill, the payments are not to be considered as parochial relief, nor are the recipients of the public charity to be classed as paupers, even the principle of deterrence will tend, in practice, to count for nothing, and the new order will indeed be the glorification of Mrs. Gamp. What it will mean to the general practitioner who is chiefly dependent upon her work, only the general practitioner will know. But it will certainly not tend to benefit the parturient woman, nor will it lower the rate of infant mortality, as it ostensibly is meant to do. For if the principle of the public payment of the medical practitioner who is called in to see an obstetric case is recognised as just by all parties, and obviously it is, then it is far more important to the general well-being of the patient concerned, and it is far more efficacious in the lowering of the rate of infant mortality that the advice of that medical practitioner should be sought in the latter months of pregnancy, before labour has begun, when the possibility of any complication arising during labour may be foreseen and prevented, than that the medical practitioner should be called in when the unfortunate complication has already occurred. Only so will there be any material saving of life, and limb, and health. Only so will one of the pernicious causes of the scourge of infant mortality be effectually faced and overcome.

The great objection to such a procedure is, of course, the economic one of its being far too expensive. But if the principle of the public payment of the medical practitioner who is called in by a midwife is accepted to-day as necessary and just, then, surely, the public will obtain far more value for its money if that medical practitioner is called in in the latter months of pregnancy than in the latter stages of labour. We see no reason why a clause should not be inserted in the Bill under discussion to the effect that it be made compulsory upon every midwife who is engaged by a pregnant woman to seek immediately the advice of a general practitioner as to whether the pregnancy and the labour would tend to be normal. Such a practitioner would receive a small fee for his advice, and any abnormal condition existing in the

patient would be discovered, and, if possible, corrected, and suitable precautions would be taken to prevent any possible complication. If any such complication should arise during the labour, the same medical man would be consulted, and the total amount of his fees, paid either by the Board of Guardians or the Public Health Authority, as public opinion may decide, need not amount to more than what he would at present receive if called in an emergency to a case by the attendant midwife. If no abnormal condition was present, and if no complication arose during the labour, then the medical practitioner would only be paid the small fee for his advice, and the management of the case would be left entirely and safely in the hands of the attendant midwife. If such a suggestion as this was adopted, the welfare of the parturient woman and her unborn babe would be ensured, the public would receive full value and entire satisfaction for its money, and the general practitioner need fear no more the competition of Mrs. Gamp. With all due deference, we humbly call the attention of the profession and the public to the suggestion here outlined. For we believe that there are but two courses of action open, either of which would have to serve as an alternative, if some such suggestion as this is not adopted—either that the education of the midwife will have to be wider in its scope, that the midwife will have, in fact, to qualify as a medical practitioner in obstetrics, or that Clause 17 will have to be abandoned. The former course is as foolish and as unnecessary as any proposal to teach a farrier the details of veterinary medicine, *or an oculist the difficulties of ophthalmic diagnosis.* The latter course would be the more welcome if there had not been the primary difficulty of the medical practitioner to recover his fee from the patients concerned. It was that difficulty, among others, that had called for a Departmental Committee to consider into the working of the Midwives Act of 1902. It was that difficulty that had necessitated the inclusion of Clause 17 in the Midwives Bill of 1910. But if Clause 17, while it will remove that difficulty, will at the same time work disastrously against the medical practitioner in his practice, as we have tried to show that it will tend to do, then it is both right and proper that the medical practitioner should ask for its rejection or for its amendment along the lines of the proposal herein suggested. It is for him to decide what would be the better course for him to pursue. H. F. S.

Portrait of the President.

The portrait of Mr. Cosmo Bonsor, our President, painted by Mr. Herbert Draper, and exhibited in the Royal Academy for this year, is now in position in the Court Room, and can be seen on application at the Counting House. A carbon reproduction has been prepared. Particulars will be given by Mr. Williams at the Counting House, where a specimen is on view.

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

Out-Patients' Cards.

DEAR SIR,—May I appeal through your columns to those members of the Staff who preside at the various Out-Patients' Departments, and to their clerks, to assist the dressers by preserving their cards, and adding some indication as to the correctness or otherwise of their diagnosis and treatment?

Only a dresser knows how valuable such information is to him in his appointment.—I am, dear Sir, yours, etc., A DRESSER.

[Some time ago we advocated this system in "Passim," and we are glad to find that it has been adopted in several departments, with great advantage to the dressers. Its adoption in all the departments as a part of the routine is probably only a matter of time.—ED.]

My Month on Gas.

Although at eight I hate to rise,
And break my fast with sleepy eyes,
By nine o'clock to be at Guy's,
I have to do it now.

For all this month it is my fate,
By nine to start to dislocate
Poor "outers'" jaws, or else irate
The H.S. will become.

To start work at this awful hour
My cheery nature soon will sour.
I'm sure 'tis not within my power
To work so hard for long.

If they would only make it ten,
Or fetch me in a motor, then
I might, perhaps, take up the pen
And sign my name in time.

But altogether I'm afraid
That these suggestions I have made
Will bring to me no welcome aid
In my pathetic plight.

A few more months of this will make,
My life a thing I'd gladly take,
Or else some navvy's jaw I'll break,
And he will give me peace!

DENTAL DRESSER.

Guy's Hospital Physiological Society.

AN ordinary meeting of the Society was held on Monday, November 14th, in Class-room I. Mr. Ryffel occupied the chair, and 49 members were present.

An interesting paper was read by Mr. S. S. B. Harrison on the "Secretion of Urine." A brief résumé of the paper is as follows:—

The two theories of urinary secretion obtaining at the present day are somewhat modified from those originally propounded by Ludwig and Bowman some seventy years ago. Bowman's theory, devoid of an experimental foundation, supposed the secretion of urine was due to the active intervention of the renal cells. Ludwig's theory explained the secretion of urine as purely mechanical, the energy required for the mechanical process being ultimately derived from the heart beat. Ludwig, moreover, supported his views by innumerable experiments on animals.

To take the glomerulus first, the majority of experiments made by recent observers tend to discredit the Ludwig view of its acting simply as a filter, letting through a fluid exactly similar to the urine, except that it is much more dilute. However, in some very recent experiments by Messrs. Barcroft and Straube on rabbits and cats, in which they poisoned the tubule cells by injections of caffein, corrosive sublimate, and also bled the animals, they found an isotonic urine secreted. Thus, under the conditions of the experiments, the glomerulus did act as a filter, but whether it does so under normal conditions we do not know.

With regard to the tubule, it seems certain that its function is one of secretion and not of absorption, though under pathological conditions absorption undoubtedly does take place.

The next meeting of the Society will be held on Monday, November 28th, at 4 o'clock, in Class-room 2, when Mr. J. Stephenson will read a paper on "Hypnotism."

H. W. EVANS, Hon. Sec.

Change of Address.

R. J. Gibbings, L.D.S. Eng., from 82, Dutoitspan Road, Kimberley, Cape Colony, to Manica Road, Salisbury, So. Rhodesia.

Fleet-Surgeon F. Davidson Lumley, R.N., from R.N. Sick Quarters, Wei-Hai-Wei, North China, to H.M.S. *Warrior*, Second Cruiser Squadron.

(The Editor will be very glad to receive a postcard with notes of any change of address.)

Guy's Hospital Dental Society.

A MEETING of the above Society was held on Friday, November 11th. The President, Mr. H. C. Malleson, occupied the chair, and the minutes of the previous meeting having been read and confirmed, he called upon Mr. E. R. Williams to read his paper on "Casting." This proved to be very interesting and instructive, and the discussion which ensued showed that the subject was one which appealed to the majority of the members present. The following gentlemen took part:—Messrs. Neft, Morrish, Mayer, Barr, Morris, Wain, Henderson, Bull, Doubleday, Wade, Passmore, Samuels, Tanner, Shore, and the President. Some excellent casual communications were shown by Messrs. Webb, Tustian, Wain, and Messenger.

H. D. S.

Reviews, etc.

Books for review should be addressed to The Editor, Gazette Office, Guy's Hospital, S.E. Their price should in every case be stated.

Diseases of the Joints and Spine. By Howard Marsh, M.A., M.C., F.R.C.S. New and enlarged edition. Thoroughly revised by the author and by C. Gordon Watson, F.R.C.S.

We are very glad to see the new edition of this work after fifteen years. It is of special interest to Guy's men. In passing from the septic to the aseptic stage, the surgery of tuberculous joints advanced along two distinct lines. The one school tried to eradicate all the disease by cutting it away; in other words, to perform an excision or an excision of the joint, and of this school Sir Henry Howse was one of the ablest exponents. Just a mile away Mr. Howard Marsh was practising the methods of the other school, who applied the new antisepsis to the older methods of rest and of simple drainage of abscesses. Time has decided between the two, and at Guy's nowadays an excision of a joint is as rarely seen as anywhere else.

This book is written by one who persistently advocated the treatment which has proved to be the right one, and we can well recommend it for many practical hints on the way to treat each joint in the body. We cannot understand the omission of any mention of induced hyperæmia, even if the authors do not advocate its use in the treatment of joint disease, yet we feel that some short discussion of its value, or want of value, should have been put in. In other ways the book has been brought well up to date; several short articles on vaccine therapy have been included;

two new chapters are added on infective forms of arthritis. Rheumatoid arthritis and osteo-arthritis have been marked off one from another, and literature as late as Mr. Robert Jones' excellent article on "Internal Derangement of the Knee," in the *Annals of Surgery* for December, 1910, has been referred to. We can especially recommend the two chapters "On Bone Setting" and on "Movement and Massage" to the reader; besides these, the chapters on Bursæ, on Loose Bodies, on Internal Derangement, and on Anchylosis will be found of great value to the student reading for an examination. Some X-ray photographs have been added which greatly help, also four coloured plates, two of these of a tuberculous knee-joint and a hæmophilic one are excellent.

In conclusion, we can only congratulate Mr. Watson for having the opportunity to revise such a work, and Mr. Howard Marsh in having Mr. Gordon Watson to revise it for him.

Papers by Guy's Men.

C. Gordon Douglas, M.A., M.B., B.Ch. Oxon: Periodic Breathing at High Altitudes: The Determination of the Total Oxygen Capacity and Blood Volume at Different Altitudes by the Carbon Monoxide Method.—*The Journal of Physiology*, No. 6, Vol. xl., 1910.

P. P. Laidlaw, M.A., M.B., B.C. Cantab.:—

The Action of Tetrahydropapaveroline Hydrochloride.—*The Journal of Physiology*, No. 6, Vol. xl., 1910.

A Reversed Action of the Vagus on the Mammalian Heart: The Fate of Parahydroxyphenylethylamine in the Organisms.—*The Journal of Physiology*, Vol. xli., Nos. 1 and 2.

W. Arbuthnot Lane, M.S. Lond., F.R.C.S. Eng.: The Use of Plates and Screws in the Operative Treatment of Fractures (Illustrated).—*The Practitioner*, November, 1910.

A. Ernest Maylard, M.B., B.S. Lond,: Primary Sarcoma of the Stomach.—*Annals of Surgery*, October, 1910.

L. A. Parry, M.D., B.S. Lond., F.R.C.S. Eng.: Two Cases of Malignant Pustule.—*The Lancet*, October 29th, 1910.

Cecil Price-Jones, M.B. Lond.: The Variation in the Sexes of Red Blood Cells.—*British Medical Journal*, 5th November, 1910.

George F. Still, M.A., M.D. Cantab., F.R.C.P.: Enlarged Tonsils and "Adenoids."—*The Clinical Journal*, 9th November, 1910.

William Sheen, M.S. Lond., F.R.C.S. Eng.: Endo-aneurysmorrhaphy (Mata's Operation), with an Account of Three Cases.—*The Clinical Journal*, 9th November, 1910.

F. W. Pavy, M.D., LL.D., F.R.S., and another: On the Governing Influence of Environment on Enzymic Action.—*The Journal of Physiology*, vol. xli., Nos. 3 & 4.

Charters J. Symonds, M.S., F.R.C.S. Eng.: The Treatment of Central Osteitis by Metal Drains. (Presidential Address delivered before the Medical Society of London.)—*The Clinical Journal*, November 16th, 1910.

W. Hale White, M.D., F.R.C.P.: Two Clinical Lectures on Typhoid Fever, delivered at Guy's Hospital.—*The Clinical Journal*, November 23rd, 1910.

Papers, etc., Received.

Industrial Tuberculosis. By T. D. Lister, M.D. Lond., F.R.C.S. Eng. (Reprinted from *The Lancet*, October 15th, 1910.)

Specialism in Medicine. An address delivered at the commencement of the Winter Session of the Post-Graduate College, West London Hospital. By Donald W. C. Hood, C.V.O., M.D., F.R.C.P. (John Bale, Sons & Danielsson, Ltd.)

Appointments.

Civil.

GODSON, A. H., M.B., B.C., F.R.C.S., Surgeon to the Oldham Infirmary.

Military.

Colonel P. A. WEIR, M.B., C.M., I.M.S., is permitted to retire from the Service, Oct. 26th, 1910.

From the Gazette's Special Pathologist.

ALL specimens—particularly those of solid tissues—should be accompanied, if possible, by a short clinical and post-mortem history, and a postal order for 2s. 6d. An extra charge of 6d. per slide is made when prepared sections are to be forwarded.

Directions to be followed in sending *Diphtheritic Membrane*;—Remove as much of the membraneous exudation as possible with a pair of forceps, which have been sterilized by boiling water. Place the exudation in a small, perfectly clean empty bottle, with a well-fitting glass stopper, and forward without delay. No preservative fluid should be used. The specimen must be accompanied by a Postal Order for 5s. A telegram will be despatched immediately the examination of the specimen is completed.

Diphtheria specimens are to be labelled *Immediate*.

Specimens, Letters, and Postal Orders should be addressed to the MANAGER, Gazette Office, Guy's Hospital.

Sport.

Rugby Football.

GUY'S v. LONDON WELSH.

With a team weak through injuries to various players and unavoidable abstentions, Guy's got beaten on the Honor Oak Park ground on Saturday, November 12th, by 8 points, 1 goal and 1 try to nil. Of the side originally chosen, Millett, Saner, Moberly and Digby did not turn out, hence much re-arrangement. Lacey returned to his original post of full-back, L. Horsley came in for Moberly, Tweed went to three-quarter, and Davies did duty at the scrum base for Saner. The Welsh also were not at full strength, and their scores, coming early in the game, made them on good terms with themselves, and they never looked back. Maddocks was their outstanding figure; Edwards and Evan Davies also lent valuable assistance.

The first try was gained by Edwards, who had backed up a forward movement which was finished off by some smart handling. The try was not converted. Maddocks started the clever tactics that led up to the next score. Fielding neatly in midfield, he transferred, and several Welshmen joining in, quick hand-to-hand work left the ball with Evan Davies and the Guy's defence beaten. Davies put down under the crossbar, and Evans had no difficulty in scoring. Half-time was taken with no addition to the score sheet.

The second half of the game was in favour of the Hospital, but though they pressed frequently, the luck was apparently against them. Once Roberts had a grand chance; he fielded the ball in the open, and with a clear run, instead of making for the line, he punted, but Edwards fielded the ball, and chased back to halfway. Stringer saw little of the ball, and when he did get a chance, Maddocks marked him very persistently. One or two runs of Stringer's looked like succeeding, but it takes more than one three-quarter, however good he may be, to turn the fortunes of a game when one is so thoroughly singled out as Stringer was by the Welsh defence on Saturday week. The Guy's forwards got the ball, and, after half-time, stuck to it, wheeling the scrums and going on with it. Several rushes were admirable; Roberts was in the van of most; Stranack and Kennedy backed him up. But though many runs got the ball up to the line, none got it over successfully; if the ball was worked across, a Welshman always reached it first. Lacey put up a great defence. Without him the Welsh score would have been higher. The game began very late, so that the last 15 minutes' play was difficult to follow. The final score was the same as at half-time, viz., London Welsh 1 goal 1 try to Guy's nil. Team:—

GUY'S.—G. E. W. Lacey (back); L. B. Stringer, M. Tweed, A. S. Roe, T. Flooks (three-quarters); —. Davies, C. H. Medlock (halves); G. R. Hind, O. G. Parry-Jones, C. S. L. Roberts, W. S. Stranack, R. S. Kennedy, T. D. Stout, A. W. A. Davies, L. Horsley (forwards).

REMARKS.—Lacey, as previously stated, played one of his best games. The three-quarters had few chances, they were practically new to each other, and Tweed was so new to the position that one cannot say much about the line. Medlock was at a disadvantage playing behind Davies whose methods he has yet to learn. Davies, though very light, was extremely plucky; though he was frequently smothered he played quite a good game. Many of his openings and attempts to get the ball away were spoilt by the off-side tactics of the opposite half. The forwards did well in the tight and in the close rushes, but the following up might have been much more energetic. The tackling was an improvement on the Oxford match form, but some of it is still much too high to be effective.

GUY'S v. LONDON IRISH.

This fixture, played at Honor Oak Park on Saturday, November 19th, ended in a win for the Irish by 3 tries (9 points) to 1 try (3 points). The result was unexpected, as the London Irish had not hitherto been successful in a single game. Guy's were without Stokes, Moberly and Saner. Stokes' absence makes a great difference, but even taking the fact that the Hospital were short of these three men into full reckoning, a very different ending should have been recorded to that given above.

The Hospital men started with every promise that they would pile up points, and for the first ten minutes or so they were in great form. After some excellent passing, Stringer was almost over, but finding the way barred he cross-kicked, unfortunately a little too hard; it looked certain that a try would result. Stranack made a great effort to reach the ball ere it rolled over the dead ball line. After this the London Irish pack began to dominate the situation. A high punt was mulled between Lacey and Millett, with the result that O'Keefe, who had followed up, kicked over the line and scored a try, which, but for both men going for the ball and both missing it, would never have been obtained. Getting in each other's way was rather a failing of the Guy's men in this game; it was probably due to over-anxiety, especially as Guy's had not managed to pull level at half-time.

The second half had not long commenced before Flooks put up a try, after the backs had handled neatly. Hind missed the place, and the scores were thus level. It was a hard fight from now onwards.

Once or twice it looked as if Guy's must get over again. Lacey put in a great dribble, but every advantage gained was soon nullified by the hard play of the Irish pack.

Before the close, Guy's started a passing run in midfield. Lacey, when it came to his turn, found Flooks too far ahead, and realised this too late, with the result the ball was flung loose. Pantlin, the visitors' left wing, pounced on it. Showing good pace, he reached the line unopposed. Millett brought him down, but too late to prevent Pantlin scoring as he fell over the line. Another try by Barrett on the opposite wing brought the game to a close, with the points standing as previously stated. Team:—

GUY'S.—H. Millett (back); L. B. Stringer, G. E. W. Lacey, —. Nicholl, T. Flooks (three-quarters); —. Davies, C. H. Medlock (halves); G. R. Hind, C. S. L. Roberts, W. S. Stranack, R. S. Kennedy, T. D. Stout, A. W. A. Davies, O. Parry-Jones, L. Horsley (forwards).

REMARKS.—The leading players for the side, those who have been for some weeks engaged twice weekly in hard matches, are in need of a rest. The forwards did not get the ball sufficiently often in the scrum, and they were very slow to break up. The following and backing up was extremely lethargic. Davies does not get the ball away cleanly, while the marking of both halves by the Hospital pair was very defective. Medlock must run straight; time and again he ran across without gaining a yard. He still "hangs on" too long. Nicholl made a very excellent first impression; he did a lot of good work. The other men dropped passes with monotonous frequency, while their formation was often so ragged and ill-placed, that for attack and defence equally, good results were almost impossible. High punts by the backs that do not find touch should be followed up with all speed. One noticed a strong tendency to make these punts and leave the following up to those who were the more energetic, letting those men get on side as best they could. Such a practice is not good football, and suggests slackness. Millett can scarcely be blamed for the reverse. He was quite sound.

The whole side need to get back their keenness. A week's rest will work wonders. There is no reason at all why future matches should not find the excellent material of which Guy's XV. is composed again in the forefront of London Rugby.

The two fixtures between the United Services and Guy's have been altered as follows:—On November 30th, the match is to be played at Portsmouth. On February 4th, 1911, the match is to be played at Honor Oak Park, instead of the opposite, as stated in the fixture lists. The alteration has been made as the Services sometimes have difficulty in raising a team for away mid-week matches.

Association Football.

GUY'S HOSPITAL v. WEYBRIDGE.

GUY'S, 2 GOALS; WEYBRIDGE, 1.

This match was played at Weybridge on Saturday, November 19th. Though Weybridge played almost the same side that beat Guy's in the Final of the Surrey Cup last year, Guy's, playing five Second XI. men, reversed the result this time, victory coming to them in the last few minutes of a really good and fast game.

Weybridge were the first to get going, but play soon went to the other end, where G. Neely tricked a back and passed neatly to Veale who had no difficulty in scoring.

Before the interval, Livesay got through for Weybridge, and ends were changed with the scores level (1—1).

The football was quite good in the second half, and both sets of forwards got going nicely on several occasions. Livesay and Veale were prominent with good shots which just missed the goal, but no further scoring accrued till Rice very neatly tipped in an excellent centre by Bevis. The hospital defence saw to it that Weybridge had no chance of equalising in the few minutes that remained. Team:—

GUY'S.—H. C. Rook (goal); S. H. Russ, M. T. Wallis (backs); V. F. H. Golledge, H. B. Neely, C. D. Neale (half-backs); G. Neely, C. E. Rice, R. M. Veale, D. Wain, S. W. Bevis (forwards).

REMARKS.—It is very satisfactory to note that five Second XI. men can come up to the First and play as well as they did in this match. Wain did no end of work, but must give up trying to get through alone, especially when he is up against a good back. Rice played a brainy game, his cross passing being especially good; he rather neglected his partner, G. Neely, though the latter made the most of his chances. Veale and Bevis were both very good, the latter having an immense amount to do. The halves were a good line; Golledge must keep his passes down, but his tackling, as with Neale, is his best part. Russ played a fine game, and Wallis, though out of his place, was very fair. Rook was reliable, and made one excellent save near the end.

The Second XI., who now seem to have got well together, also won their match v. Bank of England II., as did the Third XI., who played the City of London School II.

Marriage.

PILBEAM—PHIPPS.—On September 7th, at All Saints, Stroud, Gloucestershire, E. Laurence Pilbeam, L.D.S. Eng., to Marie, second daughter of Mr. and Mrs. Maurice Phipps, of York Villa, Stroud.

ED.—A. N. C.

GUY'S HOSPITAL GAZETTE.

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Passim.

THE General Election now in progress has some special interest for our readers in that two old Guy's men are candidates, as well as the general interest which it has for everybody. Dr. R. O. Moon again contested East Marylebone in the Liberal interest, and was again unsuccessful. Dr. J. Court is again the Unionist candidate for North-East Derbyshire.

SIR VICTOR HORSLEY'S candidature for the University of London seat has given rise to considerable interest. Among the Committee for promoting his election we notice the names of Sir Samuel Wilks and Dr. John Wade. A manifesto signed by a number of medical electors of the University of London has been issued, independently of party politics, to emphasize the importance of returning the medical candidate, in order that medical opinion on the various Bills affecting the profession which are likely to be introduced may be adequately expressed in the House of Commons. This manifesto is signed by Dr. Starling, Dr. Lauriston Shaw, and Dr. E. W. Goodall, among Guy's men.

IN the current issue of *The Hospital* will be found an article, one of a series on Eminent Hospital Chairmen, dealing with the work of Mr. Cosmo Bonsor as Treasurer of Guy's Hospital.

AMONG the medical men who have recently received municipal honours is Mr. S. R. Alexander, M.D., M.R.C.S., an old Guy's man, who has been elected Mayor of Faversham. His election to the mayoral chair is believed to be without precedent, in that he has been previously unconnected with the Corporation. He has, however, taken a part in public life as Chairman of the Governors of the Faversham Grammar School, as a trustee of public charities, as Governor of Wreight's and Gibb's Schools, and as the representative of London University on the higher education committee. As Mayor of Faversham, Dr. Alexander becomes a Baron of the Cinque Ports, and as such will be commanded to attend at the Coronation of the King in Westminster Abbey.

ACCORDING to the *Morning Leader* of Nov. 18th, at a meeting of the Board of Guardians for the district, an attack was made on the system of public vaccination in Bermondsey. The public vaccinator was specially criticised for the method employed of obtaining a sufficient number of cases for the purpose of instructing students in the principles and practice of vaccination. It was alleged that the pecuniary reward attracted mothers from other parishes, so that an unfair burden was thrown on the Bermondsey rates, and also that among the very poor the money payment tempted them to throw away the vaccination shields immediately after the operation, so as to be able to bring the children a second time for vaccination, and thus to obtain another shilling. It was contended by the Rev. Herbert Williams, who introduced the discussion, that the cost of instructing students

in vaccination ought to be borne by the State or by the hospital authorities.

THE *British Medical Journal* has made an important pronouncement in its medico-ethical column. In answer to "Witch of Agnesi" it gravely remarks: "We do not consider it a breach of professional etiquette for a house-surgeon, or a registrar, to correct grammatical errors in a dresser's notes." You ward clerks who split infinitives, or jumble up your relative clauses, or even you who write "accomodation" beware! for the house-surgeon (!) or registrar may now, without any breach of professional etiquette, come down upon you. But in return, it is quite open to you to express publicly your opinion of them for so doing, also without any breach of professional etiquette.

WE are indebted to Dr. Henry Blatherwick, of Dulwich, for a copy of the "Chronicles of the Guyites," in commemoration of their dinner held at the Star and Garter, Richmond, in 1877. The "Guyites" was the oldest Guy's dining club in existence at that time. It was customary for a pamphlet, called the "Chronicles," to be published after each of their dinners, and each member who could not attend had to write a letter for the publication giving an account of his doings for the year. Dr. Blatherwick writes that his father, who at this particular dinner was chairman, and Sir Samuel Wilks were for several years the only surviving members of the club, and met each year alone to dine at the Star and Garter, until they mutually decided to dissolve the club.

AT a meeting of the Blues Committee, on November 17th, the following Blues and Half Blues were awarded:—

Rugby Football, 1909–10.—Full Blue: R. S. Kennedy; Half Blues: M. Tweed, O. Parry Jones, A. H. Harkness, A. S. Roe, H. Millett, B. F. Sampson.

Association Football, 1909–10.—Full Blues: H. B. Neely, V. E. D. Bergh, K. J. Keer, S. W. Bevis, J. Kyle; Half Blues: J. E. Rhys-Evans, V. F. H. Golledge, W. Matthews, C. E. Rice, E. L. Jones, C. D. Neale, A. F. Camp.

Cricket, 1910.—Full Blues:—W. E. S. Digby, R. M. Neale, A. F. Rook, A. C. Hancock, R. S. Kennedy; Half Blues: M. Scott, H. C. Rook, A. H. Harkness.

Tennis, 1910.—Full Blues: H. Barber, R. H. Lucas; Half Blues: G. W. King, H. S. Groves, R. Farrington.

Athletics, 1910.—Full Blue: J. A. Barrow-Clough; Half Blues: H. Parry Price, A. P. L. Johnson, W. T. O'Kane, W. R. Gwyn Davies, W. H. A. Pratt.

Boxing.—Half Blues: A. C. Hancock, 1910; G. D. Eccles, 1910; W. S. Stranack, 1909.

Gymnastics, 1909.—Half Blues: L. Bromley, J. A. Barrow-Clough.

Cross Country, 1909–10.—Half Blues: J. A. Barrow-Clough, A. P. L. Johnson.

Shooting, 1910.—Half Blues: H. Hogben, L. D. Wright, J. E. Rhys-Evans.

Swimming.—Half Blues: M. Pern, W. J. D. Smythe, J. H. Rhodes.

THOSE of our readers who send Christmas cards to their friends could not do better than purchase some of the special hospital cards which are printed by Messrs. Ash & Co., Ltd. The cards are decorated with views of the hospital, and several new subjects have been introduced this year. They may be obtained by nurses from Miss Smith at the Matron's office, and by men from the Librarian. Through the kindness of Messrs. Ash & Co., Ltd., who, each year, present the proceeds of the sale of these cards to the hospital funds, it becomes possible, at a cost of only twopence, to send a seasonable greeting and a pleasant souvenir of the place to a friend, and at the same time to benefit the hospital funds.

Appointments.

Military.

Lieutenant F. A. BARKER, I.M.S., to be Captain, with effect from 27th July, 1910.

Lieutenant F. J. KOLAPOREWALLA, I.M.S., having completed his course at the Royal Army Medical College and at Aldershot, has been finally admitted to the Service. His commission will date 29th January, 1910.

Civil.

FLOYD, S. G., M.D. Lond., District Medical Officer to Orsett Union.

HOLMAN, C. Colgate, M.B., B.C. Cantab., M.R.C.S., L.R.C.P., has been appointed Assistant House-Surgeon to the Leicester Infirmary.

READER, N. L. M., M.B., B.S. Lond., M.R.C.S., L.R.C.P., has been appointed Senior House-Surgeon to the Clayton Hospital, Wakefield, Yorks.

A Method of Reasoning-out some of Life's Problems.

PREFACE.

To indicate that everyday life provides a fund of knowledge.—Before endeavouring to organise these thoughts that others may read, I should like to render thanks to the various sources from which hints and information have been gleaned. I, usually a very fully-occupied and so somewhat ill-read person, but here rather the dreamer, am conscious of no special treasure-houses of knowledge, so thank all, from the experts and friends with whom Providence has been kind enough to bring me into contact to the wayside tramp or beggar whom interest or possibly curiosity have induced me to question or walk with, from the exact scientific work to the gallery half-penny journal, for the hours spent in the strenuous work of life and those of early morning quiet contemplation, for the unavoidable absorption of the multitude of impressions of the past and the mysterious stimuli to interpret these, and finally to the desire to express to others, which desire, though accompanied by hesitation and a sort of fear, is yet impelled by the hope that the interest of a few may be stirred, and even some good be done by one without authority, this lack of authority itself possibly being an advantage, for I write not to spend time or to teach, but hoping to touch the chords of harmony in others' minds, that from those stores later my own small fund of knowledge may be added to.

A word of apology: I feel I am able only awkwardly to depict in words the mental pictures as they appeared to me. I ask you to think on the subject so vast, and forget the clumsy and halting expression.

To have our eyes open to probable self-delusion.—In reasoning it is a most difficult task to preserve our mind from prejudice; this difficulty is chiefly due to the fact that past impressions are a medley of facts and our own and others' deductions, and that the amount of knowledge and experience (*i.e.*, registered impressions) is limited to the powers of our senses, the greater part of it coming to us atom by atom and by deputy, as it were, for we commence this life with a potentiality of varying degree, but no fund of knowledge, and if the definition of progress given later be accepted, how wonderfully is this race watched over as regards its opportunities for steady advance, the units reproducing themselves and inheriting those portions of the potentialities of the acquirements of preceding generations necessary for the preservation of the race, and adding, according to the individual free efforts, an expanse of power to be transmitted; what a handicap it would be to be born with this medley as knowledge, and what chaos later in the struggles to discern the differences between facts and fictions or wrong deductions of the past ages.

To be continually teaching ourselves under sound principles.—We are always prone to forget that we are as children in knowledge one year as compared to the next, but that each year adds also the disadvantage of increased prejudices; it would be wise if we more often reminded ourselves of the stages and principles of a child's education and applied them to ourselves. To every human life there are two sides, the physical and the intellectual; of the former we know the limitations, while the latter may climb to undreamt-of heights, and up to a point the same principles may be applied to both; but while a man's hand may deliver a blow to the length of his arm, and only by deputy of mechanical ingenuity to a greater distance, the influence of his brain may be world wide, yet the intellectual cannot thrive without the healthy physical basis; such principles of a child's education may be considered under three main groups which we may briefly enumerate, the first being (*a*) Nutrition; (*b*) Cleanliness; (*c*) Strength and endurance with utility for protection.

It will at once be recognised that the cultivation of these principles is as essential to the intellectual as to the physical; the promotion of harmony within one intellectual life and the consideration for the race (or love of God, His gifts, and your neighbour) involves the selection and incorporation of helpful material, and the climbing from discord also involves the rejection of the unfit. The terms selection and rejection at once bring forward further the second group of principles: (*d*) Order or method; (*e*) Discipline (others' guidance); (*f*) Self-control. Remembrance of the interdependence of the parts of a body and the members of a community, and the great forces of the world, urges the importance of this group; from the cultivation of these come the profitable working of the potentialities of each life for itself, the community, and (having regard to the fact that the race is propagated by stages, the individuals reproducing their kind) for the race. Under the guidance of these principles, therefore, are worked out the economy of life's capital, the present happiness of the community and the future progress of the race.

The third group consists of the training of the means of acquiring knowledge and the ways of revealing that knowledge to others: (*g*) Observation and (*h*) Expression.

The former without the latter would be valueless to the race, and if it ever existed and vanished, its loss would be comparable somewhat to the burning of a million pound diamond to carbonic acid gas, and yet the power of speech is one which we appear to be allowed to cultivate rather as an accidental accompaniment to the acquiring of knowledge than for its own value. Observation may be regarded as, firstly, the act of registering the impressions of national phenomena by any of the senses as sight, hearing, smell, taste, touch, and also might be added the mysterious, or inefficiently explained, phenomena known as teleopathy, clairvoyance, second sight; and secondly, the interpretations of and deductions from these impressions so registered.

It appears reasonable to compare the end organs with photographic plates, the delicacy varying in different people, the impressions being thence transmitted to a subordinate centre or centres in which they may be stored again to varying extent; from these again they

may be transmitted either direct or through a co-ordinating centre to a higher centre, which centres are developing and have developed according to their varying potentialities through the life of the individual and through the ages passed through by the race, the intellect of the individual being measured by the power of drawing upon and interpreting the accumulated funds. Therefore we may say that observation may be divided into stages—

1. Reception of the sense impression.
2. Transmission to a lower centre in minutely divided portions through possibly one or more subsidiary exchanges, as it were.
3. Co-ordination of the new with the existent.
4. Registration.
5. Transmission, if stimulated or called upon, to a higher or intellectual centre or centres.
6. The interpretation and utilising of the whole.
7. The faculty of selecting from and building upon, at will, the fund accumulated, and thence to expression of the structures so built.

Intelligent expression may be divided into somewhat similar stages in the reverse direction.

From this brief analysis it can be readily seen how difficult is the truth or the expression of a fact, for we know how the senses can be blinded by our own and others' suggestions, so often have discoveries been made, appeared to stand the tests of others investigations, and yet, later, in the light of new knowledge, been discarded.

The power of initiative comes as a result of revelation, and revelation is merely the lifting of a cloud of ignorance, prejudice, or wrongly interpreted impressions of the past from the mind's eyes, which cloud is dissipated by the inner development of man through logical interpretation of the outer impressions gathered; hence the eagerness to gather as much as possible and the best possible.

The following is intended to convey a comprehensive suggestion of the fundamental processes in the advance of the world, then a rough picture of a solution of that problem that interests all of us, namely, life itself.

What are the most obvious phenomena that observation reveals to us, or that we have gathered from the revelations of others?

I would say that the term *changes* seems the most inclusive of these phenomena.

The consideration of changes induces us to classify many groups of facts:—

1. *Cycles.*—We note the recurrence of day and night, and the seasons, the necessities for labour and rest, the stages of growth followed by decay, the reproduction of new life and again this ending in death, even the clothes we wear dissipate into dust, which dust may be utilised by other forms of life after many changes. Again, in history we find revealed the ascent of nations, races, then errors of vice, and luxury, indifference, or evil personalities bringing about a decline.

2. *Differentiation.*—Thus there are the earth we walk upon, the sea, the air we breathe, the heavens above, and other planets in the heavens; we give terms to such states as solid, liquid, gas, æther, and recognise that there may be other states which are not defined. Science ascertains that all substances consist of blendings in various ways of simpler forms which it terms elements, and that these elements are probably differentiations of a simpler and universal form. There are also the divisions into the different kingdoms, mineral, vegetable, animal, and spiritual, and these again into their parts and sub-divisions, man turning most things to his use, and providing stimuli to more changes of form. Man's body itself shows a wonderful differentiation of parts for functions—brain, heart, lungs, etc.—(he struggles to unwrap the mysteries of life, and speculates on further differentiations hereafter); and each new generation differs from the old, more especially in the higher development.

3. *Evolution.*—The seed becomes the tree, and the infant becomes the man, the unknown comes to fame, the animal ascends to intellectual morality, man is still climbing the ladder of knowledge, and endeavouring to promote the higher intellectual life of his race. Water has become a power to drive engines by the adaptation of its expansion into steam, petrol also by its combustibility; England has become an empire; the wild places have become civilised colonies. From Christ has developed Christianity. Thus perfecting, adapting, developing, selecting, discarding, organising, and ranging in series, all of these processes may be included in this group of changes known as evolution.

4. *Gradual and sudden or continuous and discontinuous or merging and contrasts.*—Solution or mixture and compound or new formation; Delta formation, or earthquake and volcanic eruption; Slow development of the existent or the appearance of new life; Blending of characteristics or the appearance of a freak; Plodding calculation and earnest investigation or revelation by so-called inspiration.

5. *Observation and reasoning deduction reveal at least two important laws in all these types of changes.*—

(*a*) *Order and some controlling power* pervades everything, the whole and all the parts; there is interdependence among the resultants of all types. Under the same conditions similar events take place: Mass attracts mass, the earth attracts the bodies upon it; The earth rotates on itself and revolves around the sun: Man's brain controls his body, the course of his development follows certain rules, which rules are the building-up of ages.

(*b*) *In all the changes no loss is involved.*—There is dissipation and recollection, but only change of form; No new thing is produced from nothing; Forms of energy and material are replaceable by others, but no absolute loss occurs.

Deductions.—There is no pre-eminent importance of any one of these groups but in the *combination* of all, and we may deduce that, just as there is evidence of the laws written, in the minute phenomena that we are able to observe, so there would be evidence of the same laws in the infinite beyond our ken, that the creation was the beginning of the operation of these laws, that all changes since have been purposive, that differentiation and

evolution in the cycle-like series of changes have accomplished something, and therefore that the end of the cycle is not quite coincident with the beginning (it is not an exact cycle), that this purposiveness applies to the whole as to the infinitely small units, to the progress of the universe as to the race of man in it.

Definition of progress, and application to the problem—What is progress, what are its ways and its end? Progress is advance upon an infinity of paths of infinite length *from infinity of chaos to infinity of cosmos*. We cannot describe an infinity of chaos and the picture of infinite diffusion which the mind summons up becomes almost harmonious, but there is the mighty difference between the inertness of chaos and the life of the perfect harmony (here is the infinite cycle).

The Creation.—Let the seeing mind picture its own idea of this infinite diffusion, its less than atoms with neither attraction nor repulsion, force nor motion, combination nor division, without law or change, then as it looks as a mind conceives, so a change comes over the scene, these less than atoms become pervaded with or converted into force; the simplest pervading motion, a luminosity, perhaps, is induced by some mysterious controlling power, differences are produced, by attraction and repulsion combinations are evolved, with new forms of motion in small systems, great systems and the whole, the components and the systems acting and interacting with one another, but all obeying the universal controlling power; these forces and combinations gradually bring about a condensation of matter and energy, while the controlling power preserves a cycle-like or systematised but always progressive motion. Of some small portion of these primæval condensed masses of matter we may conceive our planet composed with its primary electrons, atoms or molecules, and their varying combinations always acting and reacting, following the laws of purposive creation or progress, producing changes, evolving more and more complicated compounds through the agency of the forces existent and the development of new, with storage and disruption of matter and forces taking place side by side, and as the ages advance changes of the mighty masses, of their minutest components, of their radiations and appurtenances and powers, mysterious to us, until revealed by greater knowledge, continually take place as part of the grand scheme of evolutionary advance, all induced by the infinite power, and ultimately possibly becoming one with it in the harmonious whole through the agency of man, no longer man but ascended to the Divine.

The formation of what we usually term Life.—We have seen from the above that some life pervades everything, but it is necessary to define what people regard as life. Life is that stage in the organisation of some portion of matter which is characterised by the acquirement of the power of selection and assimilation of many forms of other matter, and the building up of these, or portions of them, to form its own substance, and also the power of setting forth a portion of itself with the capabilities named, and of growth to an almost exact reproduction of itself.

Into the chaos of infinite diffusion of matter with no affinities or laws the coming, from a mysterious power, of a form of motion, created differences of relation, which differences become forces as between neighbouring portions, but without alteration of the dependence upon the initial controlling force; these forces again induced other differences, which, to maintain order in the great whole, tended to groupings by reason of the development of affinities within the differentiated portions; thus have we traced organisation to combinations of matter induced by developed forces, while within the combination the original force still holds sway (in such combinations there must also be some route by which to trace one to the other, all having come from a common source).

We may picture our simplest atoms as the simplest combinations, and different atoms as differing combinations; this conception of the forces of differing affinities suggests the course of evolution of more and more complicated combinations; firstly, the union of atoms with atoms to form molecules, then the mixing or compounding of molecules into the list of differentiated substances, water, rock, air, etc., then the simple organic compounds, then the differentiated groups of these. By careful observation science has advanced sufficiently to indicate the tendencies of affinities, and to estimate the various potentialities of both the simplest systems (the atom) of matter formation and of the compounding of these, to deduce almost the relative positions in their motions in molecular space of such portions as are most ready to take hold of some approaching atom or group of a neighbouring molecule, to build up compounds into more and more complicated structures by addition or substitution of dissimilar atoms or groups, to show that the possible rearrangements become greater and greater in number, but that all still follow certain laws. Reasoning indicates that orderly motion and purposive arrangement of the atoms persists throughout, while the whole possesses the potentiality of the sums of the initial forces of the simplest components; among these developments come such combinations as are diagrammatically expressed as open chains, systems of interunion, as rings or spheres etc., or combinations of these within the ring or without, with certain atoms controlled in their motion by the surrounding atoms, and so stable, while others are moving in such a way as to be ready to attract or be attracted; thus has science deduced the composition of the carbon compounds up to the benzene, the naphthalene, pyridene, and quinoline groups and the suggested composition of certain alkaloids, etc., extracted from sometime living matter, and have speculated upon the intimate structure of living matter itself.

From this basis we may conceive the evolution and differentiation by merging and steps, in small cycles and great cycles, into more and more complicated compounds, with greater and greater potentialities, and also such combinations of these so lightly held, that one portion might be regarded as being in mixture with or solution

of the others, with their molecules constantly changing their arrangement as regards the whole, and also especially as regards those portions which, having unstable affinities, are always attracting and repelling one another according to their relative potentialities (or the minute counter-part of electrical charges), and also are in a varied state of readiness to combine or exchange with any extraneous atoms or molecules which may be presented to them, building them up into a modified new substance; it will at once be realised that such entities as the above may be of an almost infinitely varied type, yet all may have reached the state of matter which is usually called "life," their potentialities varying with the initial forces collected, and with the amount of recently freed or nascent bonds ready to combine.

Having carried our thoughts and reasoning to this stage we can conceive also that:—

1. Such conditions may arise as the absorption of one form by another, or the potentiality of one type being so much greater than that of another, that the necessities of the one are taken the more readily by the other, that the former perishes by diffusion or becomes inert, etc.

2. Internal changes can also take place (a kind of crystallising or fixation as it were), such that the nascent bonds become saturated within themselves by interunion to a larger fixed molecule, and so the potentiality for external combinations (assimilation) becomes less and less, till again the inert is reached (age advances and material death comes).

3. Internal changes of the reverse type may take place, such as a hypernascency, and the formation of such a potentiality as may be capable of independent existence and more growth, and the acquirement of new powers, etc., and so the still further differentiation to more varieties.

4. Later there may develop such combination of these entities that while each may be independent, in the sense of possessing its own activity, yet that it depends upon the whole or another group for the acquirement of matter for the carrying out of life's processes, this matter itself being as much living as the cells (so-called) elaborating it.

5. Order accompanies the development of these combinations such that one portion becomes a controlling portion, or centre of internal action (just as there is order within the entity itself probably, one portion directing the waves of attraction, others being sensitive to outer attractions, others conducting such to the controlling centre, and so on), others become differentiated in function, so there is adaptation to more varied environment and greater possibilities of further advances; with inequalities so developing, the race with the greater differentiations will have increasing advantages over others.

The actions of substances, and the products of different forms of life upon one another, and upon the living matter itself, forms a subject comprising the whole of physics, chemistry, physiology and pathology, etc. If we have but a rude picture of the evolution of living matter our studies of disease will tend to become less empirical, so let us cultivate observation, and also develop our reasoning faculties to varied powers to N dimensions.

P. W. L. C.

Nursing News.

Matron's Office.

On November 12th, Nurse MacKenzie Kennedy left the Hospital on completion of her three years' training.

On November 22nd, Nurse Lowe, Head Nurse in the Out-patient Department, left the Hospital on completion of her three years' training, and Probationer Scott was appointed to succeed her as Head Nurse.

On November 23rd, Miss A. Tilbury, who completed her three years' training in July, 1909, and has since been on the Staff of the Private Nurses' Institution, was appointed Probationary Surgical Night Sister.

On December 6th, Nurse R. Miller, Head Nurse in the Theatres, was transferred to Queen Ward, and Probationer Todd was appointed to succeed her as Head Nurse in the Theatres.

Miss R. McMorland, who completed her three years' training in April last, has been appointed Nurse at the Metropolitan Amalgamated Co.'s Works at Saltley, Birmingham.

The following candidates from the Guy's Institution were successful in the recent examination for the C.M.B. Certificate:—H. M. Banbury, E. V. Krauss, E. J. Lucas, D. Oliver, A. S. M. Tucker.

We much regret to record the death of Miss Eva Lavy, who lost her life on board the ill-fated "Kurdistan," which foundered about 60 miles off the coast of the Scilly Isles on October 19th, 1910. The only survivors were two sailors who were picked up 26 hours afterwards. Two female bodies were washed ashore on the coast of Brittany, but they were unrecognisable, and were buried immediately. It is thought one of them may very probably have been that of Miss Lavy, who was returning to her work at Baghdad, after a few months' holiday in England.

Miss Eva Lavy entered Guy's as a Probationer in September, 1899, and on completion of her training was transferred to the Private Nursing Staff for eighteen months. She worked at the Mildmay Cottage Hospital for fourteen months, and in 1906 went out as a Missionary Nurse under the Church Missionary Society, to Baghdad, Turkish Arabia. We received particulars of the disaster from the C. M. S. Secretary, who writes that Miss Lavy is a great loss to the Mission, where she laboured for some years with great devotion.

Retinitis Pigmentosa and Night Blindness.

By A. W. ORMOND.

PART II.

(*Continued from page* 447).

The pigment formed in the retina comes from its outermost layer, the hexagonal pigment cells, and is due to a proliferation of these pigment cells, the pigment being carried into the retina by leucocytes. Some of the newly-formed pigment cells seem capable of amœboid movement also, and some may actually grow into the retina as a result of proliferation. The cases of congenital stationary night-blindness, however, usually show no pigmentation in the fundus.

In 1831 a young conscript, Pierre Mirebagues, claimed exemption from military service on the ground that he was unable to see at night time. He lived at the little village of Vendémian, near Montpelier, and stated that his father, grandfather, and great-grandfather also suffered in like manner. Subsequently the facts of the case were investigated, and recently much information on the matter has been obtained and published. The disease was, apparently, as far as records can prove, introduced into the family by one Jean Nougaret, who was born in 1637, and it has continued to affect his descendants, who to-day show the disease in certain members. These night-blind people have no other physical defects, and see as well during the day as other people, but on dark nights or in very dim twilight they are completely blind. They can, of course, learn to guide themselves in familiar places, and seem to recognise the presence of obstacles by some movement or displacement of the air, a capacity which has been remarked for many years in totally blind people. These congenitally night-blind people are unable to go beyond their village unless the moon is up, or they have a guide or lantern, and the children have recourse at night to walking with heads erect, arms extended, and hands open. In these cases the condition is present at birth, does not progress, and never leads on to blindness. The fundus oculi is normal in appearance, the ophthalmoscope showing no changes.

We are told that certain nocturnal animals (owls) have no cones in their retina, only rods, and it is the rods alone that possess the visual purple. With dark adaptation, that is to say, with the adaptation of the retina to dim light, we notice that we lose our sense of form much more rapidly and completely than our appreciation of light and shade; in other words, there is much more depreciation of central than of peripheral vision, consequently that portion of our retina which is most important for enabling us to move about in a dim light, is the peripheral portion containing the rods; the rods being few near the macula, and absent at the yellow spot, but increasing in number towards the periphery. Variations of light and shade are more important to us in moving about in dim light than are accurate interpretations of form; consequently it is probable that these night-blind people have some hereditary defect of their rods, or the visual purple.

Another type of case is that of children who have patches of xerosis conjunctivæ and night blindness without marked ophthalmoscopic changes; these children are generally only seen during the spring or summer months, and it is a very difficult matter to understand what connection these altered patches on the conjunctiva have, with a retinal affection involving the rods.

The changes in the conjunctiva consist of small triangular or irregular shaped patches covered with fine dried foam; they are usually in that portion of the conjunctiva which is left uncovered by the lids, and the patches are unmoistened by tears.

The epithelium has undergone keratinisation, and the greasy-looking secretion consists of fat, epithelial cells, and Xerosis bacilli. I find that these children improve if given cod-liver oil and if their general health is improved; and the degeneration of the conjunctival epithelium may be due, as also may the night blindness, to a condition of malnutrition which is improved by diet and general treatment. I use the word malnutrition here in a wide sense, and I do not mean that these children are wasted or marasmic, although a more serious, but somewhat analogous condition, kerato-malacia, is undoubtedly due to marasmus; but the epithelium of the retina and of the conjunctiva may be depressed by the chemical action of certain rays of light in patients deficient in some substance supplied usually by fat, or a more generous diet.

Similar inferences might be drawn from the occurrence of nyctalopia in cases of scurvy, vegetarianism and the puerperium. In nyctalopia, Hess has shown that it is not correct to suppose that the peripheral vision alone is affected. He concluded, as a result of studies of various cases of night blindness, that the rod-free area of "dark-adapted" eyes was less sensitive than normal, and we cannot for a moment suppose that in retinitis pigmentosa the rods

only are affected; the pathological changes are much too gross to suppose that; but the night-blind condition is noticed before the other symptoms and is the symptom to which the patient's attention is drawn on account of his total inability to see at a time when others experience no difficulty at all.

The prognosis of congenital night-blindness is that it remains stationary and is unaffected by treatment; the night-blindness associated with xerosis and malnutrition improves and disappears with appropriate treatment.

In true retinitis pigmentosa the vision slowly and continuously fails, but I have not seen a case of total and complete blindness due to this cause, although some are recorded; but I have seen many in which the vision has been very bad, and the patients quite unable to see to read, or to go about by themselves. It is easy to take a gloomy view of the prognosis in these cases, but we must never forget that it is quite unjustifiable to emphasize the termination of a disease when the end is very remote and the result hopeless.

Treatment.—As the hereditary congenital stationary night-blindness seems to conform somewhat to Mendelian principles, and to act as a dominant, the only way to stamp out the disease is to prevent the marriage of the affected, an impossible condition; once present it continues unretarded by any known treatment.

The cases of night-blindness associated with xerosis conjunctivæ, are best treated with fats, internally and locally. Cod liver oil, sardine oil, olive oil, cream, butter and fats of all kinds internally, and castor oil, vaseline or olive oil dropped in the conjunctival sac, usually effect a cure. Protection of the eyes from a strong light by tinted glasses, and improved hygienic conditions, also help in obtaining a good result. It is said that the percentage of hæmoglobin is reduced, and I have found iron and arsenic excellent tonics in these cases.

Of retinitis pigmentosa, a recent writer on treatment says, "treatment is without effect, and blindness is inevitable in advancing age (50 years or so); as a placebo potassium iodide may be given internally, or injections of strychnine on the constant current." This is too gloomy. Nothing is more certain than that any serious illness, or exhausting condition, such as profuse hæmorrhage, etc., will cause a rapid progress in the disease; therefore the converse must be true, viz., that the patient's condition is improved by the maintenance of his general health at its highest possible point.

Some years ago, Doyne recommended a diet of raw retinæ of sheep and oxen, and he is satisfied that it is of use. He says, "I think probably the benefit arises from it merely as an article of food and not from specific action; the retina is starved of blood, which brings the pabulum to the tissues, and the way this food acts is probably by surcharging the diminished supply of blood with the exact constituents that the retina needs." Doyne also advocates the removal of the crystalline lens when there is an opacity at its posterior pole, and this certainly is to be recommended, as an opacity in the lens close to the nodal point is probably the cause of the failure of central vision, which is noticed in some of these cases, and which leads the patient to state that he sees better in a dull light than in a bright one.

The Physical Society.

THE fifth meeting of the present session was the occasion of a Pathological evening, and was held in the Wills Library on Wednesday, November 30th. Mr. J. G. Saner occupied the chair.

The following specimens were shown:—

1. Idiopathic Hypertrophy of the Colon, by Mr. F. D. Saner.
2. Malignant Growth of the Testis, by Mr. Perceval.
3. Torsion of the Great Omentum, by Mr. H. N. Eccles.
4. Abscess in the Heart, by Mr. Birks.
5. A Dissected Cleft Palate, by Mr. Tanner.
6. Calvarium showing Early Senile Atrophy, by Mr. Layton.
7. A Thickened Calvarium. ? Osteitis Deformans, by Mr. Layton.
8. Ectopia Vesicæ with Prolapse of Meckel's Diverticulum, by Mr. Thompson.
9. Partial Intrauterine Amputation, by Mr. Thompson.

Mr. Webster, Dr. Cameron, Messrs. Layton, Penny, George, and Honorary Secretary contributed to the ensuing discussion. The meeting then adjourned for coffee.

Change of Address.

C. C. Holman, M.A., M.B., B.C., from Guy's Hospital to Leicester Infirmary, Leicester.

K. T. Khong, B.A., M.B., B.S., from Guy's Hospital to 38, Love Lane, Penang, Straits Settlements.

E. E. B. Lauder, from 27, Acton Vale, Acton, to Old Manor House, Carshalton.

N. L. M. Reader, M.B., B.S., M.R.C.S., L.R.C.P., from Guy's Hospital to the Clayton Hospital, Wakefield, Yorks.

(The Editor will be very glad to receive a postcard with notes of any change of address.)

NOTICES.

EXAMINATIONS FOR COMMISSIONS IN THE ROYAL ARMY MEDICAL CORPS.

The next examination of candidates for Commissions in the Royal Army Medical Corps will commence on Wednesday, January 25th, 1911, but candidates will be required to attend for physical examination, etc., on the 23rd and 24th.

The number of Commissions for competition on this occasion is not less than fifteen.

Candidates must be between 21 and 28 years of age at the date of the examination, and must hold diplomas recognised by the General Medical Council as qualifying to practise in Great Britain and Ireland.

The examination will be conducted in the subjects of Medicine and Surgery.

The written part of the examination consists of commentaries on cases set by the Board of Examiners, and reports on cases examined by the candidates. The remainder of the examination is of a clinical and practical nature. The examination is arranged to test the practical knowledge and experience of candidates.

Copies of the regulations for admission, and an account of the conditions of the Service under the Royal Warrant of 1909, may be obtained on application to the Dean of the Medical School, or to the Director-General, Army Medical Services, War Office, Whitehall, S.W.

Successful candidates will be duly notified as to the date and place of joining.

HIS MAJESTY'S INDIAN MEDICAL SERVICE.

A competitive examination for not less than fourteen appointments to His Majesty's Indian Medical Service will be held at the Royal Army Medical College, Millbank, S.W., and at the Examination Hall, Victoria Embankment, London, on the 23rd January, 1911, and five following days.

Copies of regulations for the examination, together with information regarding the pay, retired pay, etc., of Indian Medical Officers, can be obtained on application to the Military Secretary, India Office, London, S.W. Application for admission to the examination, with the necessary certificates, must be sent so as to reach him on or before the 10th January, 1911.

EXAMINERS.—Dr. T. D. Acland, M.A., M.D., F.R.C.P., in Medicine and Therapeutics; Mr. F. J. Steward, M.S., F.R.C.S., in Surgery and Diseases of the Eye; Professor A. Thomson, M.A., M.B., F.R.C.S., in Applied Anatomy and Physiology; Professor E. J. McWeeney, F.R.C.P.I., in Pathology and Bacteriology; Professor M. Cameron, M.D., in Midwifery, Diseases of Women and Children; Dr. F. D. Boyd, C.M.G., M.D., F.R.C.P. Edin., in Materia Medica, Pharmacology and Toxicology.

Guy's Hospital London University Club Dinner.

The Guy's Hospital London University Club held its annual dinner at the Criterion Restaurant on Thursday, November 24th, when forty members and their friends were present. The President, Dr. Hale White, was in the chair, and a most enjoyable evening, for the successful arrangement of which the secretaries are to be congratulated, was spent.

After the toast of the King had been honoured, the chairman called on Surg.-Gen. Branfoot to propose the toast of the club. After referring to the fact that he had been called on to propose a similar toast in 1889, the speaker dilated on the pleasure it gave wanderers abroad to meet Guy's men in the most distant places, and congratulated the club on its list of members at home and abroad. He had much pleasure in proposing the health of the club, coupled with that of Dr. Hale White. Dr. Hale White, replying in a most amusing speech, referred to the difficulty of thanks under any circumstances, and particularly when called on to return thanks on behalf of a number of men to themselves for having drunk their own health. He spoke of the double title of the club, of the sense of pride aroused by its first half, and of the memories of duels between examiners and candidates which the latter brought back. Finally, he thanked the members present for having drunk their own health so readily.

During the evening Mr. H. W. Doll kindly sang several songs which were much appreciated, while Mr. Beaufort amused the company with some very clever conjuring tricks. Later, Dr. Rippmann, in response to repeated calls for a song, took refuge in proposing the health of the secretaries, Messrs. Digby and Genge-Andrews, which was drunk with enthusiasm; and the evening ended with three cheers and musical honours for Dr. Hale White. We would remind men that there is no entrance fee or subscription to the club, which is open to all London University men. Those desirous of becoming members should send their names to the Hon. Secs., Messrs. Digby and Genge-Andrews

Papers by Guy's Men.

Captain F. C. Fraser, M.D., I.M.S.: Two Cases of Snake Poisoning. Recovery.—*Indian Medical Gazette*, November, 1910.

J. F. Goodhart, M.D. (Aberd.), F.R.C.P. Lond.: Heart Strain and Dilatation. Paper read before the Medical Society of London, November 28th, 1910.—*Lancet*, December 3rd, 1910.

M. S. Pembrey, M.A. Oxon., M.D.: Observations upon Disordered Action of the Heart, so-called "Soldier's Heart."—*Journal of the Royal Army Medical Corps*, December, 1910.

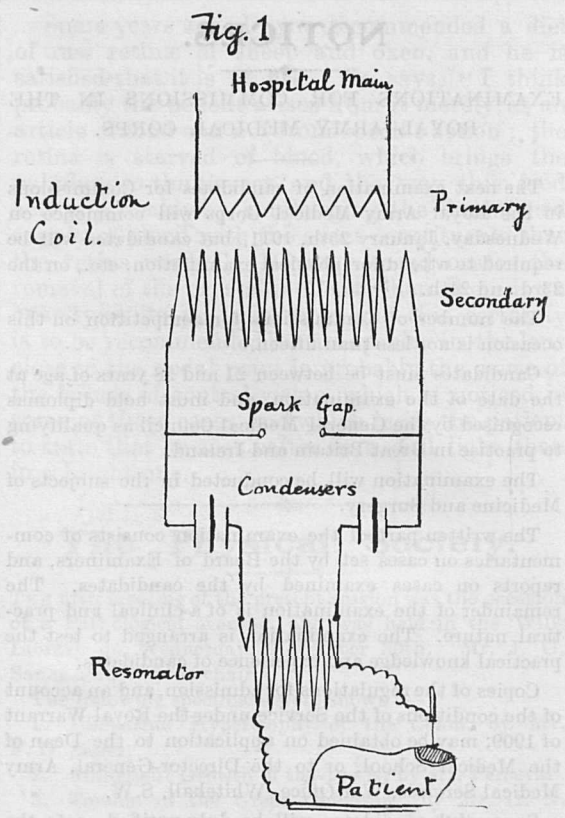
Captain C. H. Reinhold, I.M.S.: A Fatal Case of Snake Bite by Echis Carinata.—*Indian Medical Gazette*, November, 1910.

Diathermy.

CLINICAL LECTURE BY DR. C. E. IREDELL.

GENTLEMEN,—In the last few years high frequency electricity has been used as an aid to surgery in the operative treatment of cancer, and I have here a case illustrating its use. This patient, who is 50 years of age, was admitted into the hospital under Mr. Lane's care, in April 1910, suffering from growth of the upper jaw; the microscopical examination shows it to be a carcinoma. He was operated on by Mr. Lane, who removed the upper jaw, orbital plate, part of the posterior pharangeal wall, and the base of the sphenoid, all of which were invaded with growth. The whole of the operation area was then treated with the high frequency current for about five minutes; the immediate effect of this was to stop completely all the bleeding. In spite of the powerful electrical current, the patient seemed no worse than might be expected after such a severe operation, and the next morning expressed himself as feeling much better than he did the day before. At the present time he appears perfectly well, and his right eye is perfectly sound in spite of the contents of the orbit having been treated with high frequency after the orbital plate had been removed. If you look in his mouth you will see that high up at the top of the cavity formed by the lower surface of the sphenoid there is a raw surface. A sequestrum has recently come away from this area, but otherwise the whole of the surface has healed up. He is now having treatment with X-rays and Radium, as in so severe a case of cancer I think that recurrence sooner or later is most probable.

The method by which this patient was treated is known by the terms dia-thermy, and electro coagulation. The patient's body forms part of a circuit through which the high frequency current passes, and in its passage the electricity produces heat without causing any electrolysis; in this respect it differs in its action on the body from all other kinds of electricity. Figure 1 represents diagrammatically the electrical arrangements. The current from the hospital main passes through the primary of the ordinary X-ray induction coil; this induces a current of high potential in the secondary. The high potential current charges the outer coatings of two Leyden jars, the one positively, and the other negatively, until they become so fully charged that the electricity breaks across the spark gap with which they are connected. At the same time as the outer coats are charged

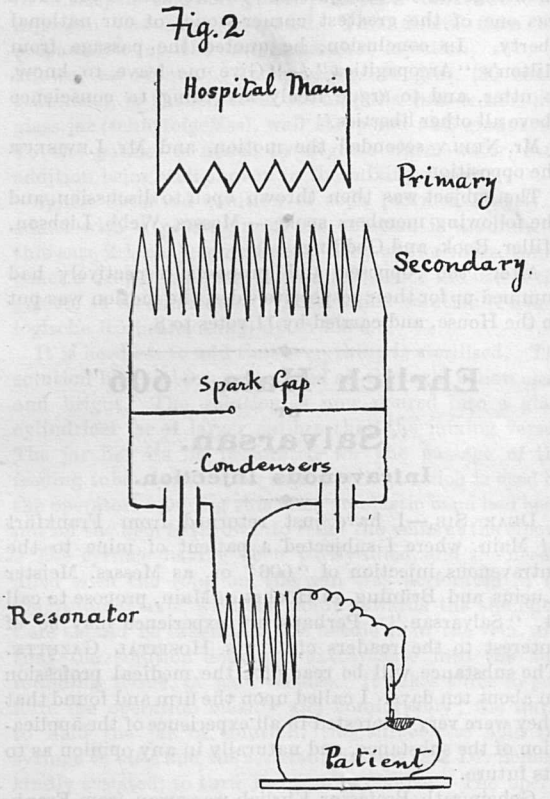


THERMOCOAGULATION.

the inner coats are charged in an opposite potential, and discharge themselves through a coil called the resonator; the process is then reversed and this alternation goes on with enormous rapidity; hence the term "high frequency."

If one end of the solenoid is connected with a metal plate on which is placed a piece of meat, and the other with a bullet-nosed electrode fastened on to a handle, which is held on the upper surface of the meat, in about a minute you see a vapour arising from the meat, and if we cut the meat through at the place we have held the small electrode, you see that underneath it, passing through the whole thickness of the meat, is a grey V-shaped area. This is coagulated meat, and is too hot to touch with the finger. Now we will take this solution of egg albumen and dip these hot wires, which we have here, in it at a distance of two inches from one another. You see that they at once form the centres of an area of coagulated albumen, but there is no more coagulation in

the part between the wires than there is elsewhere. We will now connect two similar wires with the high frequency machine instead of the metal and bullet-nosed electrode. We dip them into a similar vessel containing a solution of egg albumen and switch on. You see in a minute a line of coagulated egg albumen stretching between them instead of around each one separately, as in the last case.



Fulguration.

These experiments illustrate roughly what takes place in the human body. In practice, one pole of the high frequency machine is connected with a large metal plate applied to the back of the patient; the other pole is connected with the small bullet-nosed electrode, furnished with a wooden handle. The diseased part was treated with the small electrode. The amount of heat produced at the two electrodes is roughly the same, but the temperature is proportionately higher at the smaller electrode, so that a coagulating action is produced where it is applied, while no visible change is produced at the other. The heat waves pass in straight lines from one electrode to the other, the temperature gradually falling from its maximum at the smaller electrode to its minimum at the large. It is clear from the second experiment that the heating action has a much wider range than is the case with the actual cautery. The particular use of electric coagulation is said to be due to the fact that cancer cells have less vitality than the ordinary cells, and the heat produced causes less destruction of healthy tissue than the actual cautery.

Another method which has been used almost as widely is called Fulguration. The earlier cases treated at Guy's were with this method. Its exponents claim that by using a long spark of four inches or longer the change is produced in the tissues which makes them unsuitable for the growth of cancer, although it does not destroy the cancer cells. Originally they said that it was able to destroy small cancerous growths, but they now insist that it is necessary to remove the growth with a knife completely before it is treated with the current. They deny that any heat which may be produced by the spark has any beneficial effect, and to such an extent do they believe this that they actually cool the spark by a current of cold air of carbon dioxide gas.

By varying the numbers of spirals in the resonator the length of the spark which can be obtained from the top of the resonator can be varied, and for fulguration this is made as long as possible,

If we connect the top of the resonator with a pointed electrode so as to get as long a spark as possible, and spark on to the same piece of meat as before which is now connected to earth, holding the electrode four inches away, no effect is produced, and this is what is done in fulguration. If instead of holding the electrode four inches away, it is held half-an-inch from the meat, it becomes brown, owing to the heat generated. In the cases treated by fulguration this burning was always produced, owing to ignorance of the required conditions, and I think that the favourable results in our earlier cases were due to, rather than in spite of, the heating effect, and not to any invisible electrical action in the tissues.

I think there is no doubt that the heating effects of high frequency which have recently been brought into notice will prove of definite use in medicine, and the case I have quoted illustrates one of its possibilities.

Down Bros., Ltd., of St. Thomas's Street, London have been awarded the Grand Prix (highest award) for surgical instruments and aseptic hospital furniture at the Buenos Ayres Exhibition, 1910, as well as the Grand Prix (highest award) at the Brussels Exhibition, 1910.

Guy's Hospital Debating Society.

The Ninety-ninth Meeting of the Debating Society was held in the College Smoking Room, on Saturday, November 26th. Mr. Hamblin Smith occupied the chair.

After a division on questions of business, the meeting proceeded to discuss the following motion:—"That in the opinion of this House the institution of a Press Censorship is desirable."

Mr. Robinson, speaking for the proposition, said that the present freedom of the Press had not always existed, and freedom had been established by slow constitutional change, not by legal procedure. There was even now a degree of censorship, as shown by the laws of libel and copyright, and by the power that the police had to prosecute for obscenity or contempt of court. He quoted Lord Wynford's legal opinion of the liberty of the Press, which was "that every man should be able to instruct his fellow men, or express his opinion on any subject, or advance any new doctrines, without fear of suppression, so long as he does so with due respect to religion, morality and authority. A man's political views may be criticised, but his character must not be assailed. Character may only be assailed in the Courts of Law, where the person concerned has the power of defending himself. Criticism may not extend to vituperation; where vituperation begins the liberty of the Press ends"; and pointed out that this standard was in nowise adhered to, as character was daily assailed in the Press with vituperative violence, and speeches defaming and casting aspersions on a man's character were allowed to be published. Many of the novels extant were grossly immoral and had highly detrimental effects on children. All the coarse and revolting details of a Divorce Court scandal were repeated in the papers solely with the idea of making money. The financial columns in many newspapers were absolutely untrustworthy, while the advertisements were frequently nothing more than a delusion and a snare. He suggested that the censorship might be (i) Ecclesiastical, but this was undesirable; (ii) By Government, an inherently bad idea; (iii) Restrictive, which, unfortunately, would be impossible owing to the delay involved; (iv) Corrective. This last method alone he considered to be worthy of consideration. All that was required was that the Government should pass a law providing for the censorship of the Press, and create a Government Prosecutor. The editor should be held responsible for anything inserted in his paper, and heavy penalties should be inflicted for a breach of the law.

Mr. Charter (opposer) divided his arguments against the proposition under three main divisions—(i) The absolute absence of any necessity for a censor; (ii) The difficulty of choosing a Press censor; (iii) Disadvantages of a Press censor. The Press censor was unnecessary because the laws relating to the Press, together with the attitude of newspaper proprietors, rendered his office superfluous. There were, as mentioned by the hon. proposer, the Libel Law, the Copyright Law, and contempt of court. Who, he asked, should be the Press censor? No one censor, he continued, would be sufficient for such various subjects as religion, morality, politics and finance. He considered the disadvantages of a censorship to be obvious. It would cause a delay in the receipt of news, and its cost would be too great, owing to the creation of many high salaried officials. The liberty of the Press had been one of the greatest means of spreading knowledge among the masses. The freedom of the Press was one of the greatest corner-stones of our national liberty. In conclusion, he quoted the passage from Milton's "Areopagitica":—"Give me leave to know, to utter, and to argue freely according to conscience above all other liberties."

Mr. Neely seconded the motion, and Mr. Leviseur the opposition.

The subject was then thrown open to discussion, and the following members spoke:—Messrs. Webb, Liebson, Miller, Rook, and Godding.

After the opposer and proposer respectively had summed up for their respective sides, the motion was put to the House, and carried by 11 votes to 8.

Ehrlich Hata "606" or "Salvarsan."

Intravenous Injection.

Dear Sir,—I have just returned from Frankfürt a/ Main, where I subjected a patient of mine to the intravenous injection of "606" or, as Messrs. Meister Lucius and Brüning, of Höchst a/ Main, propose to call it, "Salvarsan." Perhaps my experience may be of interest to the readers of Guy's Hospital Gazette. The substance will be ready for the medical profession in about ten days. I called upon the firm and found that they were very interested in all experience of the application of the substance, and naturally in any opinion as to its future.

Geheimrath Professor Ehrlich was away from Frankfürt, so that I did not see him, or any laboratory work; he does not attend to patients.

Professor Trenpel, Director of the Hospital z. Heil. Geist, together with his Oberarzt, Dr. E. Schenk (who has English qualifications, and was at the German Hospital in London for some time) are especially qualified in experience of "606," and under their care my patient went into hospital. Professor Weintraud, of Wiesbaden, also takes patients.

Professor Trenpel, after careful examination of the patient, agreed as to the desirability of the intravenous method, and to suit the patient's and my own convenience, he proposed that the patient should come into the hospital as soon as possible, should go to bed, and that he would inject the next day. The patient was subjected to no other preparation.

On the following day I "went round" with the Professor, and sundry others interested, and saw the "606"

cases under his care, one intravenous, the others mostly intermuscular in the region of the buttock.

With regard to my patient, I must confine myself; it was a very suitable case for trial of the remedy. He had a pulse of 50, which with him was normal. The injection was made at 12 o'clock in the day in the largest vein in the bend of the elbow of the left arm. The site was prepared with soap and water and a brush, followed by absolute alcohol, and a moist piece of lint in antiseptic solution placed over the veins whilst the injection was being prepared. This differs from the preparation of the intermuscular injection, so well known, as follows:—The powder, ·30 grm. (30 centigrammes), is shaken from its ampulla into a tube-like glass jar (schüttelgefäss), well stoppered and graduated. To the powder is added by degrees warm water, each addition being well shaken in the mixing vessel.

When dissolved solution of soda (normal NaOH) is added with a pipette, until the solution is alkaline (in this case 2·1 c.c.), sometimes a drop or two more, sometimes a drop or two less, is required, hence the use of the pipette is recommended, Then saline solution (Physiologische Körhsalzlösung) up to 200 c.c.

It is needless to add that everything is sterilised. The solution having been well mixed all through, is now clear and bright. The solution is now poured into a glass cylindrical jar of larger calibre than the mixing vessel. The jar has its lid perforated for the passage of the feeding tube of the double action syringe which is used by the operator. During this time an elastic band had been put on the arm to throw into relief the veins at the elbow.

The syringe having been partly filled, and the needle filled with the solution, the vein was perforated in its longitudinal axis, with the point towards the shoulder. Care should be taken that the needle is in the vein, and that the solution does not extravasate into the surrounding tissue, as pain ensues. It takes three to perform the operation cleanly and comfortably; the nurse to hold the jar of solution, the surgeon to hold the syringe *in situ*, and the assistant (in this case Dr. Schenk kindly assisted) to turn the two-way valve. The operator, to know that he is in the vein, withdraws the piston of the syringe slightly when blood mixes with the solution, he then proceeds with the injection, never moving his left hand which controls the needle, or his right hand from the handle of the syringe. The injection of 200 c.c. takes five minutes. It does not seem slow.

I kept my finger on the pulse from the commencement of the operation. The pulse tension was not taken otherwise, and I was naturally anticipating increased tension; the beats only increased by 4=54; normal 50. The patient was carried back to bed; he had walked to the operating theatre, about fifty feet on the same floor as his bedroom.

I did not see the patient until after 4, but the chart and his own account give the following: At 2 p.m. he was sick, and in about twenty minutes retched excessively, bringing up bile. He had pain in his head, back, legs, and abdomen, latter rather severe, followed by full copious action of bowels.

He had 20 drops of digalen administered, foollowed by 16 later on.

About 3, his temperature was 104·5°; pulse 136. Rigors accompanied the sickness and lasted three-quarters of an hour. About 4, profuse sweating set in, and at 5, when I saw him, sweating was still in progress, but the pulse was only 126; temperature 102½°. Pains had gone, but he felt very weak, and in the four hours had gone through a very powerful and violent reaction. At 11 at night I took the pulse again, 96; temperature 38° C.

Next morning he had had a fair night, pulse 86, temperature sub-normal. Nothing but fluid, tea, etc., since the injection; the patient is an extremely strong man physically, has never had any illness beyond present symptoms, and had been nearly three weeks of the month prior to injection on full doses of arsenious acid, with some small doses of concomitant, after a vigorous course of Aix-la-Chapelle treatment and iodides; at Aix he lost 18 lbs. in weight, yet prior to the injection his Wasserman reaction was positive.

I think it will be seen that "Salvarsan" ("606") is not a substance to be trifled with, as there is reaction with the smallest doses.

I do not like to take up any more of your space, but should you think your readers would care to read of intermuscular injections and the relations of this substance to the Wassermann reaction and symptoms, I shall be happy to give them at some future time, with, I hope, a good report of my patient. I think the future of "606" lies in subcutaneous injection, as against intermuscular and intravenous.

Yours sincerely,

TOM BIRD.

P.S.—I should be very chary of giving an intravenous injection to anyone over 55.

Specialities.

Toilet Soaps.

The toilet preparations of Messrs. Edward Cook & Co., Ltd., of Bow, E., have received favourable comment at our hands on more than one occasion. We have recently received samples of their various toilet soaps, and an examination of these fully justifies the belief that this firm is determined to enhance, and not only to maintain, its high reputation in the manufacture of these goods.

Messrs. Cook have a wide variety of toilet soaps to offer, and we can testify to the excellence of them all. The choice "Throne" and "Violet Oatmeal" caskets mark the acme of saponaceous daintiness. The "Solace" casket, containing the well-known "Solace" shaving stick and other toilet accessories, will justify its name, and do much to lighten the hard lot of those unfortunates who shave. Nor are the children forgotten: we have had personal experience of the pleasure which Teddy bears in soap can give, and a Lord Lansdowne in green soap, and a Mr. Asquith in pink, and other little big soap men may bring reminders of the election even to the nursery bath. All classes, therefore, who wash, are catered for, and no one will regret a trial of Messrs. Cook's soaps.

A few Methods from the Rotunda Hospital.

T. F. BROWN, L.R.C.P., M.R.C.S.

Having spent a few weeks at the Rotunda Hospital, I thought it would interest the readers of the GAZETTE to hear of some of the methods employed at that famous Institution. On referring to my notes, the following items are worthy of mention :—

1. Method of preparation for operation.
2. Method of sterilization of hands.
3. Sterilization and use of silk sutures.
4. Use of Clover inhaler.
5. Abdominal incision.
6. Vaginal examination.
7. Curettement.
8. Prolapse of uterus.
9. Pubiotomy.
10. Extra peritoneal Cæsarean section.
11. Neville's axis traction forceps.
12. Treatment of eclampsia.
13. Treatment of mastitis.
14. Use of quinine, scopalamine.
15. Carton's mucus catheter.

1. *Method of preparing a patient for operation.*—This may be stated briefly as follows :—Previous evening hot bath ; site of operation shaved, washed with plain soap and water, using the hands only (and not a brush), swabbed with ether and painted with tinct. iodi. Then compressed with $\frac{1}{6000}$ bin iodide of mercury in methylated spirit, to sterilize and harden the epithelium.

The next day on operating table the site is swabbed with ether and painted with picric acid in bin. iodide and methylated spirit.

2. *Method of sterilization of hands.*—Wash with soap and water for five minutes, using a brush, then rinse in water and soak the hands in corrosive sublimate solution $\frac{1}{1000}$ for three minutes.

The gloves are boiled and afterwards placed in methylated spirit. It is claimed that the spirit facilitates putting them on, prevents perspiration of hands, is sterile, and finally prevents the irritating effects of the $HgCl_2$.

3. *Sterilization and use of silk sutures.*—This subject is interesting, as silk is not used extensively at Guy's. Dr. Tweedy has proved that silk is absorbed by the tissues, he having repeated a Cæsarean section after an interval of eighteen months, and found no trace of the silk sutures used at the previous operation. Stitch sinuses are unknown at the Rotunda since the following method of sterilization was adopted.

The silk (Chinese No. 1, 2 and 3) is soaked in ether for twelve hours, and then in alcohol for a similar period, and finally boiled in $\frac{1}{1000}$ $HgCl_2$ solution for twenty minutes. The stock is kept in mercuric solution, and finally boiled in $HgCl_2$ just before the operation.

4. *Anæsthesia.*—It was interesting to note that when the patient was fully anæsthetised, the I. R. bag was removed from the Clover inhaler. The regulator was then turned to I. This procedure saves the constant regular removal of the inhaler from the face, and the patient receives a modified open ether, which is quite satisfactory.

5. *Transverse abdominal incision.*—At the level of the anterior superior spines a curved transverse incision is made with the convexity downwards. This incision includes skin, fasciæ and rectus sheath. The recti are then separated vertically, and the transversalis and peritoneum incised. The advantage claimed is the impossibility of hernia, and easy method of closing the abdominal cavity, and finally the scar is almost concealed by the pubic hair.

6. *Vaginal examinations.—Do the least number possible* seems to be the keynote in the obstetric wards at the Rotunda. Great importance is attached to palpation, for the necessary information as to presentation, etc., Pawlik's and the fourth grip being the most important.

Before making a vaginal examination the men wash up, and apply rubber finger-stalls to the first and second fingers of the examining hand.

The finger-stalls, which are obtained from old gloves, are boiled, and placed in methylated spirit. Two or three dozen are kept in one basin for use.

7. *Curettement.*—Recamier's curette is used for the cornu of the uterus, after the cavity has been curetted.

Formalin solution is then applied on a Playfair's probe.

8. *Prolapse of the uterus.*—The late master said he had yet to see a prolapse without laceration of the cervix. He holds that when the cervix splits, Mackenrodt's ligament (formed from the pelvic fascia which embraces the cervix) is also split, and the natural support of the uterus goes. The repair of this condition necessitates a rather complicated operation.

Perineorraphy.—Dr. Tweedy holds that a modified Lawson Tait gives the best result. Certainly it is a rapid operation. On one occasion, as a matter of interest, I timed it from the incision to the last stitch ; the operation was completed in just under three minutes. His chief point is in bringing the ends of the levator ani muscle in apposition. May I also mention here that during the second stage of labour the perineum is never supported at the Rotunda, but flexion and delivery are assisted by pressure between the anus and coccyx.

9. *Advantage of pubiotomy.*—A patient with a contracted pelvis was admitted in labour, the conjugate being 9 c.m., or about $3\frac{3}{4}$ inches. A brow presentation was diagnosed. Craniotomy had been performed on two previous occasions.

The operation was as follows :—A Doderlein's needle was passed through the left labia majora at the level of the lower border of the pubis. The point was kept close to the periosteum, and passed carefully behind, with the assistance of one hand in the vagina, and then over the upper border of the pubes. A Gigli's saw was hooked on the needle, which was then withdrawn, carrying the saw with it. The handles having been adjusted the bone was divided.

The patient was then placed in Walcher's position and forceps applied. Delivery was rapid and easy, with a live full-term child as the result. After the 3rd stage of labour the usual binder was applied, and over this an ordinary half-crown abdominal belt was strapped around the pelvis at the level of the trochanters. The hæmorrhage was slight and the punctured wounds were covered with a sealed dressing. I saw this patient for nine days after the operation. She did not complain of pain, and on the third day was allowed to turn on her side to nurse her baby. I have since heard that she made a complete recovery and was walking on the seventeenth day.

I subsequently saw the new master, Dr. Jellett, perform pubiotomy with the same good results. Another patient operated upon ten days before I saw her walked across the ward seven days later. Being interested, I took the opportunity of asking her questions about pain and inconvenience during her convalescence, and she said they were nothing to speak of.

During the second subcutaneous pubiotomy performed at the Rotunda, the bladder was unfortunately injured and smart hæmorrhage took place, which stopped on pressure being applied. I understand that the patient made a complete recovery with no ill-effect.

10. *Extra peritoneal Cæsarean section.*—This operation is claimed to be better than the classical operation only in cases where the patient is advanced in labour, and there are suspicions of contamination by careless and repeated vaginal examinations.

The transverse incision as described above is made. The peritoneum at the bottom of the vesical uterine pouch is divided, and that portion covering the anterior surface of the uterus is freed, and then sutured to the upper edge of the parietal peritoneum. The abdominal cavity and contents are thus shut out of the field of operation.

The uterus is divided vertically, and the head delivered quite easily with one blade of the forceps and one hand. Ergotin $\frac{1}{50}$ gr. is administered at this stage. After the placenta, etc. is removed, the uterus is plugged with iodoform gauze, the end of which is pushed through the cervix into the vagina. The uterus is then closed with interrupted catgut sutures, and the abdomen closed in the usual manner. Hæmorrhage is said to be less in this operation owing to the thinness of the wall of the lower uterine segment.

11. *Forceps.*—At the Rotunda, Barnes' blades with Neville's axis tractor is used. They possess the following advantages:—(*a*) They are applied as ordinary forceps, and the axis tractor is fitted outside the vulva, after the blades have been locked. The complication caused by the ordinary axis tractor when the blades are being fitted is avoided. (*b*) As the axis tractor is outside the vulva, there are no grooved surfaces or locks to keep clean. (*c*) When the blades are in position and the axis tractor fitted, they are kept in position. The hands are then free to give more $CHCl_3$ if necessary, or for any other purpose, without fear of the blades falling out or shifting. (*d*) The axis tractor is easily and quickly removed, if so desired, when the head is on the perineum.

12. *The treatment of eclampsia.*—The mortality at the Rotunda is 7 per cent., which is very low. The following notes sum up the most important facts.

Delivery.—Accouchement forcé is not advocated. When the os is dilated delivery is assisted with forceps.

Starvation.—The fits do not last longer than three days, and during this time no food, but as much water as possible, was administered by mouth or rectum.

Chloral.—This drug is not used.

Bleeding.—As heart failure is the immediate cause of death in eclampsia, venesection is not advocated owing to its depressing effect.

Diaphoresis is not attempted, as its beneficial effect is considered doubtful.

Stomach lavage is performed to prevent fermentation of any food taken before admission, for digestion is usually retarded.

Morphia.—This drug decreases metabolism and cerebral irritability, and so controls the fits. It is given in $\frac{1}{2}$ gr. doses hypodermically, and repeated while the fits continue in $\frac{1}{4}$ gr. doses. Up to 2 grains are given in the twenty-four hours. If the respirations fall to 6 per minute, morphia is omitted, no harm resulting if this precaution is taken.

Atropine.—This drug in $\frac{1}{100}$ gr. doses is given with each alternate dose of morphia to prevent respiratory depression.

Rectal washes.—Warm water only is used. The tube is placed high into the bowel. About oj. of water should be left in the rectum.

Infusion.—$NaHCO_3$ is substituted for sodium chloride in infusion solutions for the same reason as salt, free diet is advised in nephritis.

Linseed poultices are applied over the kidneys.

Purgatives.—This is important; if the patient is conscious, Pulo jalapæ Co. $3\frac{1}{2}$ grs. is given. If unconscious, Ol. crotonis ♏ iij. in Ol. ricini ʒij. is administered at the time of the gastric lavage, 3 minims is a large dose of croton oil, but has no ill-effect.

Position.—The patient should be kept always on her side in a darkened and quiet room. If respirations cease the head is to be immediately lowered over the edge of the bed. The mucus which collects in the larynx and is probably the cause of the obstruction, will then pass through the mouth and nose. Artificial respiration should be vigorously applied.

13. *Treatment of mastitis.*—The results obtained from the following treatment are most gratifying, complete recovery taking place in the majority of cases between the second and third week. A radial incision is made and the finger inserted into the abscess cavity. Special care is now exercised to completely break down all the soft tissue. The cavity is then well drenched with creolin solution, and firmly packed with iodoform gauze. The gauze is removed daily for the first few days, and the cavity well drenched as before.

Bier's treatment has been employed, but preference is given to the above.

14. *Quinine* is used in 10 grain doses for weak pains during labour, and also for any morbidity during the puerperium.

Scopolamine is also very popular over there.

15. *Carton's mucus catheter.*—This is an admirable little instrument. It is quite efficacious in removing mucus from the larynx, and it is surprising to see the amount obtained from babes after protracted labour, especially in breech presentations.

The Rotunda method of plugging for uterine hæmorrhage is well known.

In conclusion, Mr. Editor, I must apologise for the length of this article. It is now two years since I had the pleasure of working in Queen ward, and therefore the above methods, though interesting to me, may not be new to present students.

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

The Empire, German Invasion, etc.

DEAR SIR,—I have read with interest the report in the GAZETTE of the debate on Universal Military Training. Some of Mr. Ryle's Socialistic arguments appear to me to be somewhat weak. He quotes Belgium as an instance of how safe it is for a country to be practically powerless. I agree with him, and at the same time would point out that it is a rare thing to hear of a tramp being assaulted and robbed. But England, unlike Belgium, happens to be an exceedingly wealthy country. Does Mr. Ryle imagine that if Germany invaded this country and captured London, that it would be the intention of the Germans to settle down in Great Britain? Far from it, for once in a position to dictate terms, they would vacate the country as quickly as possible, leaving us minus our fleet, minus our Colonies, and minus any money in the Treasury coffers. On these lines I grant Mr. Ryle that we shall be safer when we give up maintaining a large Army and Fleet, for once we have lost everything worth having, we shall be in the enviable position of a small country like Belgium or Denmark, and, like the poor tramp on the road, we shall be in a position of safety as regards robbery and assault, and our social position amongst the nations will be much the same as the tramp's.

Mr. Ryle says, "that twenty-seven and a half million pounds are spent annually on the Army, which expenditure is entirely unproductive." One might as well say that the police force and the fire brigade are unproductive, since neither of these actually produce money. But if Mr. Ryle will go to the British Museum and study a map of the world published to-day, and also one published one hundred years ago, he will see that the expenditure on the Army is not unproductive. The products of the expenditure he will see marked in red.

Has it not struck Mr. Ryle that if Great Britain had universal service and the strongest possible fleet, that we then, with all our Colonies to back us up, might be in such an unassailable position as to be able to insist on universal disarmament and the world's peace. After all, the shortest way to a thing is not always the pleasantest way.—I am, dear Sir, yours faithfully,

Hafod, Llandinam, N. Wales. H. BEADNELL,
Dec. 1st, 1910. (Capt R.A.M.C.).

Plague in England.

DEAR SIR,—In a most interesting article entitled "Plague in England," in your issue of Nov. 12th, a statement appears, which, I think, needs amplification. The statement is as follows:—"The notion that the great fire had anything to do with the cessation of the plague is disposed of by the fact that there were a few (2,000) deaths in London in 1666."

Now the great fire did not break out until the beginning of September, 1666. The 2,000 deaths must therefore have occurred before the fire originated, and this is the more likely if we remember that, in 1665, the plague reached its height about the middle of September. The fire must have absolutely destroyed many rats, fleas, and bacilli. Fresh air must have been more plentiful in the burnt-out areas.

Surely the great fire must have had a beneficial effect upon the plague in London.—Yours faithfully,

TRAGUS.

SIR,—In your issue of Nov. 12th there is an article on "Plague in England." I wish to draw A. E. B.'s attention to the misstatement at the bottom of page 443, viz.:—'That Glasgow is in England." It has always been considered a Scotch city, and if A. E. B. refers to the "Gazetteer," he will find, that although Glasgow has enlarged its boundaries considerably of late, it is still situated north of the Tweed in that part of *Britain* called Scotland.

J. B. N. P.

"606" and Pernicious Anaemia.

DEAR SIR,—I should be glad if any of your readers who are in closer touch with recent work than it is possible to be for one living in the Vectian wilds, could tell me whether Ehrlich-Hata's preparation "606" is being tried in cases of pernicious anæmia? Argument by analogy is notoriously dangerous. Yet the good that arsenic so often does in these cases, especially if given in the early stages and for the first time, suggests that, if one could find the right combination of arsenic (as "606" appears to be in the case of syphilis), it might be possible to give an initial dose in cases of pernicious anæmia, potent enough to kill the disease and not the patient.—I am, yours sincerely,

Shanklin, Isle of Wight, J. A. B. HAMMOND.

The Conjuror.

By FREDERIC VICARS.

Conjuring of all sorts has always had a fascination for me. Therefore, when my eye fell upon the gaudy posters of "Paracelsus, the Great Wizard and Illusionist," a little thrill of pleasant anticipation ran through me. I was acting as locum tenens for a provincial doctor, and was not overburdened with work. So I went to the professor's entertainment.

The conjuror was a middle-aged man, with a mop of iron-grey hair and dark restless eyes. A little woman, with a pinched face, presided over a piano and a harmonium, from which instruments she produced quite astonishing effects. After the usual sleight-of-hand tricks, the performance concluded with an exhibition of so-called Spiritualism. The professor made a little speech denouncing the charlatans who pretend to supernatural assistance, and, glaring round at the audience, declared he would do the same wonders by mere trickery. Then followed the Davenport cabinet performance, which was as good as any of its sort I have seen, and the audience testified to its merits by hearty applause. With the mysterious cabinet the performance concluded.

The people got up and were leaving the hall. I was among the last in the crowd, and as I lingered for a moment near the door, I saw an attendant running across the stage with a bottle of water. Instinctively I hurried back and inquired if any one was ill, saying at the same time that I was a doctor.

"'e's fainted—in there," said a man, pointing towards a room that opened on to the platform. My appearance was welcomed by the little musician, who was bending over the prostrate form of the conjuror. A moment later Paracelsus opened his eyes and looked vaguely round.

"Did I 'queer' the show, girl?" he asked.

"No—not at all—you've forgotten; it was over when you fainted. This gentleman's a doctor," she added, as she saw the Wizard looking at me.

"Ah, thanks—felt giddy in the cabinet. . . . . They were mumbling so there, I remember—" He stopped speaking and looked scared. He sipped a little water at my suggestion, and allowed himself to be assisted to a chair.

Soon after that he seemed himself again, so I bade him good-night, and promised to call at their lodgings next day.

When I paid my visit on the morrow, I found the professor just finishing a late breakfast. He rose to greet me as I entered.

After some general remarks about himself, the professor suddenly turned to me and said,

"Doctor, do you believe in Spiritualism?"

"No, I do not," I replied, emphatically.

"I suppose not," he said, eyeing me curiously. "Well, I profess to expose the humbug of Spiritualism. I have studied the performances of mediums, and I have reproduced their phenomena. I challenge a comparison." He threw back his head with an air of bravado as he spoke.

Then his face changed, and he moved restlessly in his chair. He seemed to think a moment, and he knitted his brows before speaking.

"Well, I will tell you the truth—the plain, unvarnished truth, doctor. I need not tell you what the cabinet trick is, for you saw it last night. I have performed in the mysterious cabinet for a little over a year. It has been a success in every town. About three weeks ago a strange thing happened. After releasing my right hand from the rope and shaking the tambourine, I distinctly heard the guitar twanging above my head! I dropped the tambourine in sheer astonishment, but recovered myself a moment later and made a grasp at the guitar. It was there, for sure, and when I passed my fingers over the strings I could feel no sense of vibration. The sound had ceased as I touched the instrument. It seemed strange, certainly. I supposed it was imagination or something of the sort. Anyway, I went on with the performance, and nothing further of the kind happened that evening. The next night I began with the guitar, and had hardly twanged the strings a few times when the tambourine began to shake vigorously. There was no mistake about it, for as I grasped it I felt it still quivering. Then it stopped. I confess this business made me feel rather uncomfortable, and I could not sleep that night for thinking of it. I kept wondering if there was something supernatural after all in Spiritualism. I remember I laughed as I thought of it. Here was I, exposing Spiritualism, and at the same time, perhaps, the spirits were having a *seance* on their own account! 'Rubbish, rubbish!' I exclaimed out loud several times, so that my wife asked me what I was thinking of. I did not tell her my thoughts then, nor have I since told her. Well, to continue. Every night since then something fresh has happened. I have felt hands touch my face as the doors closed. Real hands, but cold as death.

"Yes, night after night the cabinet has become a battle-ground for me. Oh, I am not the only performer. They are there, too! They are at their games directly the door closes. It is a grand competition of mysteries. I hear them mumbling curses at me for my skill in doing by trickery what they do by supernatural means. How they threaten me. . . . Threaten me! But I fight them—yes, I fight them."

He sank back exhausted as he finished speaking. Neither of us spoke for a while. It was quite evident to me that the poor fellow was suffering from hallucinations, no doubt brought on by overwork.

"Professor," I said, gently taking him by the hand, "I am glad you sent for me, as it is very necessary that you should have medical advice. I hear you finish the tour this evening; I am glad of

it, for I feel convinced that you are suffering from nervous exhaustion. These strange occurrences are really but hallucinations."

He looked up quickly.

"How do you know they are hallucinations?"

"Well, obviously they are not real. You and I don't believe in such things."

"*I do* believe in them," he replied in a firm voice, while he leaned forward and looked earnestly at me. I tried argument, but was not successful.

In vain I urged him to stop the performance at once. He said it was impossible, and stuck to it. He was "billed" for it, and could not disappoint the public. At last I gave in on his promising me that that evening would see the last of this Spiritualistic performance.

At the house door his wife joined me, and to her I explained that the professor was suffering from nervous exhaustion; that the cabinet trick took it out of him too much, and that after that evening he had promised to give it up altogether. I inquired further as to his habits, but learnt nothing beyond that he was very enthusiastic over his business.

* * * * *

That evening found me an interested spectator among the audience at the Town Hall. The professor seemed calm to-night, and the sleight-of-hand tricks lost nothing in the way of dexterity. It was only when the time came for the cabinet performance that I noticed anything peculiar in the professor's demeanour. He became restless, and the "patter" with which he accompanied his tricks was strangely mixed.

When the dark cabinet was wheeled on to the platform, Paracelsus forthwith invited two members of the audience to act as a committee during the cabinet performance. Immediately I sprang up from my seat, and with another volunteer mounted the platform.

The professor, of course, gave me no greeting, and indeed by his manner obviously wished to show I was a stranger to him.

The harmonium droned out a wailing air while we proceeded to examine the interior of the cabinet. It was a bare wooden structure, painted black. We thumped it all over in orthodox fashion, in search of trap doors and sliding panels. A plain wooden chair stood inside. Our next proceeding was to bind up the conjuror with about twelve feet of ordinary box-cord to the chair. As I struggled over the last knot I pressed my patient's hand and whispered in his ear, "Steady, now." For answer came a sigh of weariness and a wistful look. We stepped back to one side of the stage, and the music ceased. Instantly the professor seemed to rouse himself. His head was thrown back, and he strained at the ropes.

"Ladies and gentlemen," he cried, "I will now present to you my thrilling sensation, 'The Mysteries of the Dark Cabinet.' Gentlemen of the Committee, please close the doors."

The key turned in the lock with an audible click, and almost immediately the guitar twanged and the tambourine gave forth its dubious melody. At the apertures above the doors the "spirit hands" appeared, and sundry "knockings" were heard proceeding from the cabinet.

A slight pause followed, then a feeble voice cried,

"Open the doors!"

In an instant I had turned the key and thrown open the cabinet. The professor was seated in the chair, deadly pale and bound as firmly as before. A burst of applause signalled the approval of the audience. Under the pretext of further scrutinising his bonds I entered the cabinet, and bending down felt his pulse. His eyes turned to me with a wild look in them.

"Professor, stop it, for God's sake," I whispered.

"Never, till I release myself."

At this I turned round and addressed the audience.

"Ladies and gentlemen, the professor is ill. The performance ought to be stopped."

Here the professor, rousing himself, shouted,

"Nonsense, I'll go on."

"Well, as a doctor, I make my protest," I said.

There were shouts of "Right, stop it!" and others of "Go on, professor." My colleague on the platform here intervened with the suggestion that the audience should decide the matter. As he put the question to the people, I looked at the professor. He was excited and sat leaning forward, straining at the rope, his eyes flashing, and his jaw set.

I heard the question asked, "Is it your wish that the performance is to go on? Yes or no?"

In the clamour that gave the answer I heard "Yes" predominant.

"The Ayes have it," said my colleague, amidst a rowdy shout of approval.

"I will leave the platform, then," I answered, as I swung down the ricketty stairs and took my place beside the professor's scared wife at the harmonium. I can still see him sitting in his chair, pale, ghastly and immovable, like a waxen figure. As the doors closed upon him it seemed to be like the closing of a coffin lid.

A moment of breathless silence followed. Strange sounds came from the cabinet, like kicking against wood. The sounds changed to a faint tapping, and then ceased altogether. The audience waited in dead silence for the usual shout from within. None came. . . . A moment more and then the woman next me rushed forward, shrieking.

"Open the doors! Open—something has happened!"

The people in the hall rose *en masse* as the doors of the cabinet were thrown open, and, with a thrill of horror, we saw the conjuror held by the rope, still erect in his chair, while from his fixed stony eyeballs death looked triumphantly across the footlights.

Sport.

Rugby Football.

GUY'S v. HARLEQUINS.

Before a record crowd numbering over 2,000 and an overflowing grand stand, this match was played at Honor Oak Park on Saturday, November 26th, 1910.

There had been a frost overnight, followed by a slow ground thaw, which made the surface slippery. Nevertheless, it was a grand game to watch, quite the best match of the season, or, as one enthusiast put it, "the best game that had ever been seen at Honor Oak Park." It was hard, tremendously fast, and fought out with the utmost keenness from the initial kick-off till the final whistle.

The Harlequins had three absentees among their back division, Lambert, Maxwell Dove and Elmslie; but they were strengthened by the re-inclusion of F. M. Stoop. Guy's had Stokes away. No backs could have done much against the Guy's forwards on the day. They were splendid; a real live pack; on the ball; fast to break up. Every man a worker; they tackled splendidly, and went "for the man with the ball." The Harlequins were never allowed to develop their game; the spoiling was too good.

Fairly early in the game the first try was forthcoming. There was a forward rush by the hospital, and Stranack touched down. Medlock took the kick, and converted nicely. Heartened by this success, the forwards kept up the pressure. Medlock received from Saner and was almost in. Then came a rush to the other end, where Cranfield was collared almost on the line. A scrum was ordered after Lacey had recovered; he was "winded" tackling Cranfield. Guy's worked back after a drop-out from the twenty-five yard line, and some excellent work by the Harlequin and International forward, G. D. Roberts, brought the first half to a close.

Early in the second half, F. M. Stoop got away. He dashed off for the line at a great pace, Lacey managing just to push him into touch in goal. Still pressing, Stoop opened up the game, and some good passing worked the ball to Howitt. Flooks got to him, but could not hold him; consequently, he went over for a try, to which Cranfield failed to add. Guy's gradually got back to concert pitch, Jones' defence and touch-finding being splendid indeed. Stranack was prominent with a good run, and then came a sensational piece of play. The Harlequins started a typical bout of passing, F. M. Stoop coming along nicely, with Lacey facing him, passed, Lacey snapped the ball, and dashing off, got clear away till he reached Lloyd, the Harlequin back. Lacey punted, there was a short scuffle, and the ball came loose. Medlock, who had followed up, planked it over for a great try. Hind missed the points. A great series of tight scrimmages now took place at either end; then, after a judicious cross kick by Jones, Stringer and F. Stoop raced for the touch. Stringer threw himself on the ball, but unluckily it bounced between his arms. Final score: Guy's, 1 goal 1 try (8 points); Harlequins, 1 try (3 points). Team:—

Guy's.—G. E. W. Lacey (back); T. Flooks, E. Nicholls, J. P. Jones, L. B. Stringer (three-quarters); J. G. Saner, C. H. Medlock (halves); G. R. Hind, C. S. L. Roberts, W. S. Stranack, R. S. Kennedy, A. V. Moberly, T. D. Stout, O. Parry-Jones, L. Horsley (forwards).

Remarks.—A great and splendid win. Stranack was the best forward on the field, but all the pack were excellent. Lacey played one of his best games Medlock worked most untiringly, and his backing up deserves the utmost credit. He covered a tremendous amount of ground, and is to be congratulated on a good display. J. P. Jones was "J. P. Jones"; further comment is unnecessary.

GUY'S v. UNITED SERVICES.

This match was played at Portsmouth on Wednesday, November 30th, and ended somewhat disastrously for the Hospital, the final score reading: United Services, 7 goals and 2 tries to nil, *i.e.*, 41 points to nil.

The Services had a very strong side out, practically the strongest they could find, the only absentee of note being Lieut. W. C. Wilson, the International. The afternoon was wretchedly wet, and the conditions altogether unfavourable for the game. But it was a day for forwards, and after the brilliant display of the Guy's men on the previous Saturday, it was quite thought that Guy's would hold their own. But they were overweighted by the Services' pack, as fine, hard, and hefty a pack as you could wish for. They pressed almost from the start, and after a few minutes only had gone Greig scored for the home side. The same player ran in with the second try beneath the posts. Good work by Campbell led up to the next score, Wodehouse being the actual try getter, and then Abercrombie dribbled across and touched down. Harrison converted two of these tries, and before half-time he kicked a goal from a good try by Campbell. At half-time Guy's were 21 points down.

The second half does not need much detailing. The Services maintained their great form, and as the result of tremendous work by their forwards, Mann, Wells, Royle and Abercrombie gained further tries, Harrison converting them all, the good kicking of the last-named being quite a feature of the afternoon.

Guy's.—J. E. W. Lacey (goal); L. B. Stringer, J. P. Jones, E. Nicholls, H. W. Evans (three-quarters); J. G. Saner, A. N. Other (halves); G. R. Hind, W. S. Stranack, C. S. L. Roberts, R. S. Kennedy, T. D. Stout, R. Stout, A. W. A. Davies, L. Horsely (forwards).

Association Football.

GUY'S v. CARSHALTON.

CARSHALTON, 4 GOALS; GUY'S, 2.

This match was played at Honor Oak Park on Saturday, November 26th, 1910.

The thaw on Friday night following a strong frost all the week made the ground very slippery on the surface. This did not seem to trouble our opponents, who were early together and, combining cleverly, were often dangerous. Pollard saved well several times, and mainly owing to him the score sheet was blank at the interval. Guy's made several attempts to get going, but the forwards were weak and badly supported.

On changing ends, Carshalton were quickly 2 goals up. Then Birks and Mitchell put some life into their work, and before long Mitchell opened the Hospital account (1—2). A long shot from the visitors' right wing put them further ahead. Pollard might have got to it, but seemed to stick in the mud. Guy's by now had improved, but their work, except on occasions, was much below form. A second goal, however, came from Spong, following a neat piece of work (2—3). In the few minutes that remained the Carshalton right wing was at work again, and Neale, failing to clear, they added a fourth goal. Team:—

GUY'S.—R. H. Pollard (goal); S. H. Russ, M. T. Wallis (backs); J. Kyle, H. B. Neely, C. D. Neale (half-backs); S. W. Bevis, R. W. Spong, W. Matthews, A. H. Birks, D. A. Mitchell (forwards).

REMARKS.—The Hospital side was again much below strength, five of the side being away. In spite of this, they gave quite a bad display. Pollard, in goal, alone was good, and he undoubtedly saved the side from a heavy defeat. Russ was playing well when he unluckily strained himself. The rest of the defence, except on occasions, was weak. The forwards were about the same, though Mitchell and Birks were constantly doing their best to play well. Our opponents were a very good side, about the best we have met this year, the combination of the forwards and support of the defence being excellent.

UNITED HOSPITALS v. CORINTHIANS.

This match was played on the St. Thomas's Hospital ground at Chiswick on Saturday, December 3rd, when a very fast game, full of incident, ended in a draw of three goals all.

The Corinthians had a powerful side out, and at the start it seemed that they would soon get goals so well did their forwards play. The Hospital defence, however, was equal to the strain, and by degrees the team assumed the upper hand. The forwards were well together, and a good combined run culminated in an excellent centre from King, which Birks met with his head and sent into the net. Immediately after this, Waugh fell over when clear of the backs and the ball at his feet. The Corinthians were by no means idle, but sent in several good shots which Cranston ably dealt with; they were, however, unable to draw level before the interval.

On resuming, their forwards played delightfully, Brisley and Edwards being very fast on the ball and keeping it in wonderful control, and it was not long before they were on terms. Birks, however, a minute or two later, sent in a terrific shot which gave Owen no chance, and put the Hospitals ahead once more. For the next twenty minutes the Corinthians had more of the game, and though the Hospitals' backs played splendidly, the halves were not equal to the strain, and Edwards and McIver both got through, giving their side the lead for the first time.

In the last period of the game the football was even better; the Hospitals' forwards worked with a will and in excellent combination. They were rewarded with an equalising goal, King putting across to Birks who, with another excellent shot, scored again in the last minute of a very fine game. Teams:

UNITED HOSPITALS.—W. R. Cranston (St. Thomas's) (goal); W. L. Johnson (St. Thomas's), T. W. Stretton (Bart.'s) (backs); M. E. D. Vlasto (University), G. E. Dyas (Bart.'s), H. B. Neely (Guy's) (half-backs); R. M. King (Guy's), A. C. Tonks (University), A. J. Waugh (Bart.'s), A. H. Birks (Guy's), W. C. Wale (Bart.'s) (forwards).

CORINTHIANS.—L. G. Owen (goal); V. G. Thew, J. C. D. Tetley (backs); J. E. Snell, H. G. Howell-Jones, F. N. Tuff (half-backs); R. A. Young, C. E. Brisley, C. D. McIver, V. Edwards, A. H. G. Kerry (forwards).

REMARKS.—Birks stood out prominently among the forwards, and he was well supported by King and his partner Tonks, of University. The backs, Stretton and Johnson, played splendidly all through, and the halves, though not so good, worked well; their weakness lay in feeding their forwards. Cranston in goal was quite good, and can in no way be blamed for the three times he was beaten.

Papers, etc., Received.

The Libraries of London: A Guide for Students, by Reginald Arthur Rye, Goldsmiths' Librarian of the University of London.

PERIODICALS.—The Hospital, The Clinical Journal, St. Bartholomew's Hospital Journal, The Prescriber, The Nursing Times, St. George's Hospital Gazette, St. Thomas's Hospital Gazette, St. Mary's Hospital Gazette, The Stethoscope, Prince Alfred Hospital Gazette, The Medical Review, Paris Médical.

Birth.

MITCHELL.—On November 25th, at Budsgrove, Woking, the wife of Howard V. Mitchell, M.R.C.S., L.R.C.P., of Clacton-on-Sea, of a daughter.

ED.—A. N. C.

GUY'S HOSPITAL GAZETTE.

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Passim.

WITH the return of Christmas, it becomes the privilege of the Passimist to greet all the readers of the GAZETTE at home and abroad with the conventional and none the less sincere wish for "A Merry Christmas and a Happy New Year." In the hospital these wishes are almost unnecessary, for everything making for merriment and happiness is guaranteed. Those of us who have passed a sufficient number of hospital Christmases to realise that one is much like another, can take comfort in the thought that to most of the patients, our guests, especially the children, it is a happier and jollier time than they have ever known before. It is a privilege to be able to take a part, however small, in providing this feast of happiness. This occupation of helping to make others enjoy their Christmas must, in a measure, compensate nurses and men who are debarred by their work from joining their own family circle at this season. *Dare quam accipere!*

WE give below a brief calendar of events for Christmas week :—

Dec.

Sun. 25 Christmas Day.

Mon. 26 Boxing Day. The Niggers go round the wards in the following order :—
Ruth Ward, 12; Addison Ward, 12.20; Mary Ward, 12.40; Stephen Ward, 1; Esther Ward, 1.20; Queen Ward, 1.40; Bright Ward, 2; Out-Patients, 2.30; John Ward, 2.40; Miriam Ward, 3; Patience Ward, 3.40; Luke Ward, 4; Naaman Ward, 4.20; Dorcas Ward, 4.40; Charity Ward, 5; Lydia Ward, 5.20; Job Ward, 5.40; Lazarus Ward, 6; Martha Ward, 6.20; Astley Cooper Ward, 6.40; Cornelius Ward, 7.
Out Patients' Tea, 2.

Tues. 27 Concerts in Mary, 3; Queen, 3; Christmas Tree in Martha, 3; Residents' Theatricals, 8.15.

Wed. 28 Concert in Naaman and Dorcas, 4.30; Residents' Theatricals, 8.15.

Thur. 29 Concerts in Addison, 3: Eye Wards, 3; Patience and Samaritan, 3; Stephen, 3.30; Job and Lydia, 3.30; Residents' Theatricals, 8.15.

Fri. 30 Concerts in Charity, Cornelius, Luke, and Physiological Theatre, 2; Nurses' Entertainment, 8.

Sat. 31 Concert in Astley Cooper, 7; Bonfire, 11.30.

The Residents announce an attractive programme for their annual theatrical entertainment, which will be held in the Physiological Theatre on the evenings of December 27th, 28th, and 29th. A thrilling one-act tragedy, entitled "The Ghost of Jerry Bundler," occupies the first part of the programme. It is a dramatised version of the short story of the same name by W. W. Jacobs, and ran for some time at the Haymarket a few years ago. The third part, according to established tradition, will consist of a farce. It is called "The Top of the Monument," is described as a "topical impossibility," and has been perpetrated by Mr. L. E. Berman, with some of the members of the company as accomplices. Between the two plays there will be a variety entertainment. We hear that the tickets are nearly all disposed of, and that to-day is the last date on which applications can be received by Messrs. Attwater, Elliott, Fitzmaurice, and Mills.

The following appointments have been made by the House Committee upon the recommendation of the Medical Committee:—House Physicians: N. A. D. Sharp (Dr. Pitt), G. H. Hunt (Dr. Shaw). House Surgeons: J. G. Saner (Mr. Lane), F. Kahlenberg (Mr. Dunn). Out-patient Officers: W. T. Clarke, H. Gardiner, E. P. Poulton, T. D. M. Stout. Assistant House Surgeons: F. D. Saner (Mr. Steward), G. Maxted (Mr. Fagge), G. Y. Thomson (Mr. Rowlands), C. C. Tudge (Mr. Turner). Obstetric Resident: A. Neville Cox. Clinical Assistants in Orthopædic Department: W. W. Cook (chief), W. A. Miller; in Ophthalmic Department: J. S. Bookless, L. Mandel; in Genito-Urinary Department: L. Mandel.

The following appointments have been made by the House Committee upon the recommendation of the Dental Council:—House-Surgeons: H. F. Barge, F. S. Glover, W. H. Wotton; Assistant Dental House-Surgeons: R. B. Campion, W. S. Lakeman, J. H. Rhodes.

All our readers who were at any time resident at the hospital will, we feel sure, join with us in sincere regrets that the Matron, Miss Newton, should have lost her savings in the Charing Cross Bank failure. A fund has been started by past and present Guy's men with the object of purchasing her an annuity. A letter on this subject, signed by a large number of influential Guy's men, and a preliminary list of donations, will be found in our correspondence columns. As will be seen, Miss Newton's friends have already responded generously, but many more subscriptions are needed in order to collect the desired amount. Many of the subscriptions already sent have been accompanied by letters from former residents, and commenting on Miss Newton's kindness, patience and tact in a post where those qualities are particularly desirable. She became housekeeper in the old "Rooms" in 1880; in 1890, on the foundation of the College, she became its first Matron, and she will complete her twenty-first year in this appointment in March next. Miss Newton has therefore been associated with a large number of old residents as Matron, and to these we make appeal on her behalf in all confidence that it will meet with that generous response which is characteristic of Guy's men.

Mr. William Henry Horrocks, M.B., F.R.C.S., of Bradford, whose death was recently announced, was the author of an excellent paper on "Sir Astley Cooper—His Life and Times," which was delivered as a presidential address before the Bradford Medico-Chirurgical Society, and afterwards reprinted in book form and circulated among a large number of medical friends.

At Dr. French's Friday Out-patients.

Bilateral Paralysis of the Sixth Cranial Nerve after Fractured Base of the Skull.

A boy, aged 12, was brought to the Hospital by his father on account of squint, associated with severe headaches and periodic vomiting. It was found that his motor nervous system was natural as regards his body and limbs, but that there was complete paralysis of both sixth cranial nerves. No other cranial nerve was affected. The pupils were equal, and they reacted to light and to accommodation; sometimes the axes of the eyes were parallel, but more often there was convergent strabismus, sometimes one eye, sometimes the other appearing to squint the worse. When each eye was tested separately it was found that the movements upwards, inwards, and downwards were perfect, but that when the boy attempted to follow a moving object with his eye outwards, whilst his head was kept stationary, the eyeball moved well from the inner canthus as far as the middle line, but then came to a sudden stop, though when an extra effort was made by the lad to continue to keep the object in view a slight movement of the eyeball downwards and a little outwards occurred, with a wheel-rotation of the eyeball through a few degrees at the same time; this downward and outward movement and the rotation were clearly due to the action of the superior oblique muscle uncontrolled by the external rectus. Ophthalmoscopic examination showed well-marked optic neuritis in both eyes, the filling up of the physiological cup, the active hyperæmia of the disc, and the blurring of its edges being very much more developed in the left eye than in the right. It was noted that the boy had an irregular scar over the left fronto-temporal region, and upon inquiry it transpired that the lad had fallen over some banisters, four months previously, from a considerable height, striking his head in the region of the scar upon a concrete pavement, after which he had developed extravasations of blood beneath both conjunctivæ, and had almost certainly fractured the base of his skull. It is always possible that in a case of this kind injury to the bones may have led to the development of a neoplasm, but in the present instance it seemed much more likely that the fractured base had been followed by the formation of extensive callus in the region of the basi-sphenoid bone near the sella turcica, this callus now either pressing upon, or possibly even actually including in its substance the long sixth nerves, and also behaving like any other intracranial tumour and producing both severe headache and optic neuritis.

As regards the prognosis in these cases, the probability is that in the course of months the natural process of moulding of the callus will lead to diminution in its bulk, and that the optic neuritis will simultaneously subside. Whether or not the sixth cranial nerves will recover will depend upon whether they are actually included in the callus or merely pressed upon. It is possible for a motor nerve to be sufficiently pressed upon to be unable to transmit impulses to the muscles which it supplies without the axis-cylinders of its nerve fibres becoming actually degenerated, in which case, with diminution in the pressure, complete motor power in the affected muscles readily returns. If, on the other hand, the axis-cylinders have degenerated, it is so difficult to maintain the nutrition of the external rectus muscles, which cannot be efficiently treated by massage or electricity, that even though regeneration may subsequently occur from the central ends of the motor nerves paresis of the muscles persists. In most cases of cranial nerve paralysis from fracture of the skull, however, the prognosis as regards recovery of motor power is good. That improvement was already setting in in the present instance was indicated by the fact that, whereas the headaches were still troublesome, the attacks of vomiting were much less frequent than they had been.

It is worthy of special note in the above case that the optic neuritis was very much more marked upon the side upon which the injury to the head had occurred.

Pupils' Physical Society.

The sixth meeting of the session was held in the College Smoking-room at 8 p.m. on Friday, December 16th. Mr. T. D. M. Stout occupied the chair.

A paper was read by Mr. J. B. Hance on "The Treatment of Surgical Tuberculosis by Altitude and Heliotherapy." A discussion followed, to which Messrs. Schlesinger, Cook, Hart, Pochin, and the Honorary Secretaries contributed.

A vote of thanks to Mr. Hance for his interesting paper was carried with acclamation. The meeting then adjourned for coffee.

John Hilton.

As the subject of our Christmas picture this year we have chosen the portrait of our former distinguished surgeon, John Hilton. Mr. Jacobson has kindly allowed us to reprint the following extracts from his long and interesting memoir of Hilton which appeared in the *Guy's Hospital Reports* for 1892.

JOHN HILTON was born September 22nd, 1807, on historic ground, at Sible Hedingham, in Essex. Two small villages, Sible Hedingham and Castle Hedingham, lie, a little north of Halstead, on the Colne Valley branch of the Great Eastern Railway.

EDUCATION.

Hilton was educated at the Grammar School at Chelmsford, and at Boulogne-sur-Mer. Some years later, when, as Demonstrator of Anatomy, he revisited the latter place for a holiday, an event occurred which shows what changes have taken place in the last seventy years. While travelling on the top of a diligence, Hilton found himself seated next a man in whom, now sleek and prosperous, and dressed in most respectable broadcloth, he recognised one who had retired a few years before from the business of body-snatcher. Conversation promptly followed, and in reply to a question as to what had brought him into France, the body-snatcher replied that he had come over to fetch back one of his daughters who was at school "over there." Hilton, who knew the place, said, "But they only learn a sort of *patois* there." To this the reply was, "Oh no, sir, my daughters learn French and the *patois* too."

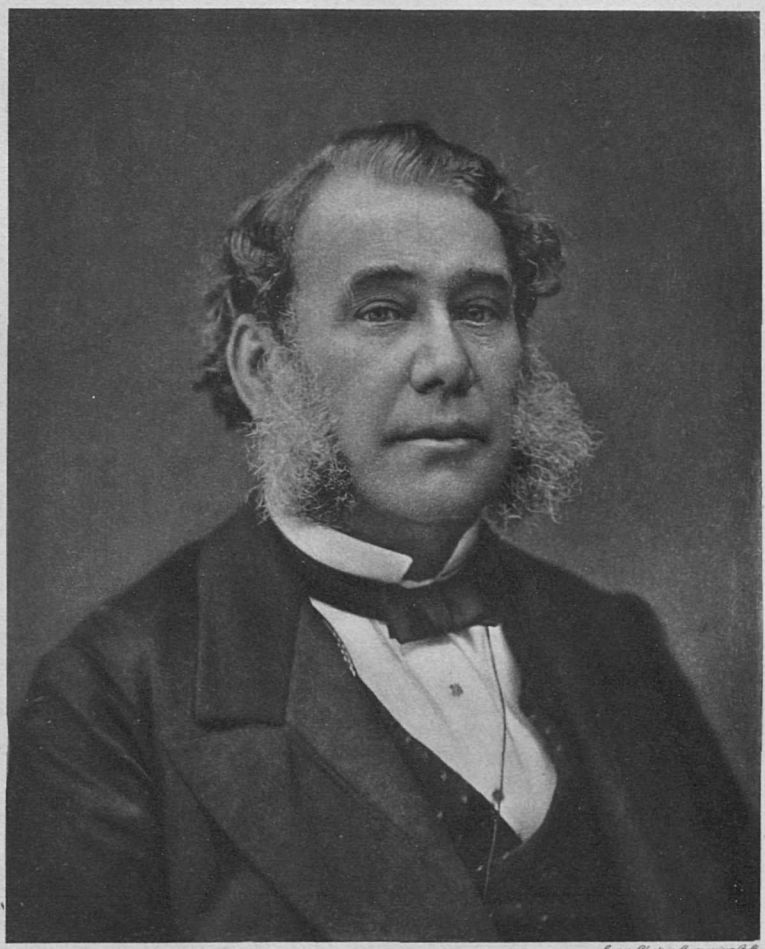
Hilton was uncertain whether this worthy was one of the brothers Harnetts or the brothers Crouch. The doings of this quartette of scoundrels are chronicled in the volumes of Bransby Cooper's life of his uncle, in the memorials of J. F. South, and in a diary which, though little known, is perhaps the most remarkable of any that this world has ever contained, 'Diary of a London Ressurectionist, 1812—13,' Royal College of Surgeons Library. How one of the brothers Crouch was called down from London "in consultation" by Liston (then settled in Edinburgh) to aid him in obtaining the body of a country lad, who, after dying of hydrocephalus, had been buried in a graveyard on the shores of the Firth of Forth; how, for weeks, the friends had succeeded in baffling the body-snatchers; how, when the excitement of the contest between the watchers and the besieging force of body-snatchers had begun to wane, Liston and Ben Crouch came down on the scene, and in thirty minutes of twilight, just before the watchers appeared on the ground, succeeded in carrying off the body, which found a final resting-place in the Museum at Edinburgh—all this will be found told in Dr. Lonsdale's 'Life of Robert Knox,' p. 66. Mr. South states—let us hope incorrectly, and unduly biassed by the rapid success with which Guy's had ousted her elder sister—that the Crouches were the sons "of the carpenter of Guy's Hospital."

Hilton's education seems to have been inadequate and incomplete, but the having to pick up things as he could probably early sharpened his natural shrewdness and acumen. At all events, Hilton's life in this respect is a proof that when a man honestly wins success without the help that a good education, money, or powerful friends can give, there must be something in that man to stamp him as above the common—much in him to honour. And we may go a step further here: it is certain that Hilton's rough outside, his want of personal attractiveness, his reserved, hard manner, and his aversion to society save that of his friends, all pointed to the fact that the early and most impressionable years of his life had been overclouded, and that he had not come out of that time unharmed.

We have no information of Hilton's student days, which must have been about the years 1824 to 1828. One story he left behind which shows how men and manners have changed. The separation between Guy's and St. Thomas's took place in 1825, but a yearly dinner was held at which the staff and their friends met—a meeting still continued under the auspices of the United Hospital Club. In one of his later student years Hilton had an invitation. Men drank hard in those days, and Hilton used to tell how, as chair after chair became vacated, either by the guests leaving or finding repose under the table, he moved up until he reached a seat of honour at one side of the chairman, the elder Benjamin Travers. It would be interesting to know what passed between the pair. Hilton could not remember how Travers took the intrusion; he only recollected that after getting back to his lodgings in Maze Pond and going to bed, he woke up in the middle of the night desirous of getting some water "to cool the tip of his tongue." His disgust may be imagined when he stepped on to a soaking carpet, and on looking for the cause at his finding that a fellow-student, who lodged in the same house, had come into his bedroom to get some water, and that he was sitting in one corner of the room pouring water out of Hilton's bedroom ewer on to the bottom of a tumbler which he held upside down, while he anathematised his thirst and his inability to quench it.

AS AN ANATOMIST.

Hilton was appointed Demonstrator of Anatomy in 1828, the second time this appointment had been made at Guy's. Mr. Cock had been the first, having been appointed in 1825, when the two hospitals were



Swan Electric Engraving Co.

John Hilton

Born 1804 — Died 1878

separated. As Hilton was without interest, it is clear that he must have already made his mark to have this appointment given him when he was only twenty-one. The time at which the appointment came to him is of importance, as it was at this time that the Guy's Medical School was in its infancy, having been opened in 1825, the final rupture between us and St. Thomas's taking place in 1836. In 1832 the Anatomical Act came into force and replaced the business of the body-snatchers, and during these years there was a third and popular school in the Borough, Grainger's, competing with Guy's and St. Thomas's. The above must have combined to make these exciting times. How differences sprang up between Guy's and St. Thomas's about 1824, how a medical school was first started, independently, at Guy's in 1825, and how the tie between the united Borough hospitals was finally broken in 1836,—all this is well told in the life of Sir A. Cooper by his nephew Bransby (vol. ii.), in the memorials of Mr. South, and by Dr. Wilks in his 'Biographical History of Guy's Hospital.' It was a happy storm which cleared the air and started our school on its own lines, with Mr. Cock as the first demonstrator in 1825, and Mr. Hilton associated with him three years later. Mr. Hilton was at this time living in Maze Pond, and if, as sometimes happened, a body was brought after the hours when the dissecting room was closed, it was placed in the cellar of the house that Hilton was occupying.

Hilton was Demonstrator for fourteen years, and was reported to be the best anatomist in London. It was these years which laid the foundation on which his name will rest. The dissecting room of that day now forms part of our Museum. The Demonstrator of those times must have been more important in some ways than at the present. There was none of that profusion of well-illustrated books at the disposal of all, at moderate prices. There was but one examination at the end of the three years, at which Anatomy had to be taken up with other subjects. Anatomy in 1828 occupied an infinitely more important position in the early training of a medical student than it does now. An attempt had only just been made, and very imperfectly, to separate it from Physiology. This blending of the two subjects showed itself in the basis of very sound if very simple Physiology which runs through all Hilton's teaching. It was natural under the circumstances that it should first appear in his earlier anatomical teaching; it was constantly coming out, later on, in his surgical work, both in the wards and in his lectures, unpublished as well as published. It is not going too far to say that it is in this sound blending of Anatomy and Physiology, coupled with the natural powers of the man, that the chief merit of Hilton's teaching lies. It is on this that his imperishable claim to be remembered as a great scientific or physiological surgeon rests, strange as it may appear to many who only remember Hilton's outer man to hear the term scientific applied to him, and still more so to those who have been trained in the physiology of 1893, to hear Hilton called physiological. We shall return to this matter later. We have alluded to it here because some of the chief colouring and the chief characteristics of Hilton's teaching date to the years with which we are dealing, and the relation which Anatomy occupied to Physiology in the year 1828. Hilton, in his earlier years in the dissecting room certainly, worked at Anatomy as no one at Guy's has ever worked either before his day or since; and the chief result is to be seen in the models with which his name and those of Towne the artist and Harrison the treasurer should always be associated. Hilton is said to have lived about the place all day, taking his lunch in a room which should correspond to the present prosector's room. It was this devotion to his subject which won him the agnomen of "Anatomical John."

Work with Towne.

The event which should fix clearly in the minds of Guy's men 1828 as the year of Hilton's appointment as Demonstrator of Anatomy was the arrival in London about this time of one who was destined to do work with Hilton which, while proving of infinite service to generation after generation of our students, has, in the lapse of years, been too much separated from the names of the three men to whom we owe it. It was in 1826 that young Towne came to London from Royston with his model of a human skeleton, called upon, and was kindly received by Mr., afterwards Sir, A. Cooper, who was so pleased with the accuracy that he gave him a letter of introduction to Mr. Harrison, the Treasurer. This man, to whom Guy's owes so much, who succeeded his father as Treasurer at the early age of twenty-six, who founded a separate medical school at Guy's; who, because he was in some ways despotic and arbitrary, was called "King Harrison," but to whose zeal and interest in the working of every detail in our school its earliest successes were largely due;—this man, who, by sheer power of judging merit, appointed three of those whose names will confer most abiding lustre on Guy's in the future—Addison, Hilton and Gull—to Harrison's memory students of the present day should turn in reverence, respect and gratitude for this also, that he, by his power of judging men, and by his foresight and knowledge of what would benefit our school —a knowledge in which he must have been immensely in advance of his day—gave us also those models in the possession of which our Museum has been without a rival, and the envy of other schools. What arrangement passed between Mr. Harrison — who had then been Treasurer for twenty-nine years, and who was not to retire until 1848, after a reign of fifty-one years—and Joseph Towne (who, then only seventeen years old, was to work for our hospital for fifty-

three years) will never be known. It was a day of an absolute despotism, which held its sway, on the whole most usefully, regardless of the modern checks which the institution of auditors has given. Mr. Bryant, in his notice of Mr. Towne in our Reports for 1882, writes, "All Towne bargained for was a room to himself, on which he could turn a key when he liked, and the promise of every kind of help from Mr. Harrison, should help be required, in the unknown work he had undertaken to originate." Later on an arrangement was made by which his salary was paid partly by the Hospital, partly by the School—an arrangement which lasted up till 1853, after which date, until his death in 1879, the School paid it all. Amongst his earlier models are his best, the anatomical ones which represent the first attempt made in this country to represent the different regions of the human body by wax, and amongst the first of these to be undertaken was the series of thirty sections to illustrate all the parts of the brain. Then followed the models made from dissections, and, as in the case of those just mentioned, by the hand of John Hilton. Before this time, owing to the difficulty of obtaining subjects for dissection, wax models had been introduced into England from Florence and Paris, some of which can still be seen in Museums in London and at the older Universities. Some familiarity with these foreign models is necessary in order to estimate rightly the value of those with which the wisdom of Harrison and the labour of Hilton and Towne have enriched our school. In the models of foreign artists it is comparatively little that is attempted to be shown, the different structures are very poorly defined, the skill of the anatomist to show and the power of the artist to represent are alike at fault; while the perishable nature of the materials used, and the tendency of the tints to become faded and blurred become increased as time goes on. On the other hand, it is difficult to know which to praise most in the handiwork of Towne—their life-like accuracy, their painstaking determination to represent details faithfully, the truthful sharpness of outline by which the different structures represented are separated one from the other, and, perhaps, above all, the abiding permanence of the colour and materials employed.

No one will ever know now how these marvellous models were made. Not only did Towne's skill and proficiency die with him, not only was his power—the peculiarity of a true artist of fixing in wax or marble what he had once seen in life or death—lost when he departed, but, unfortunately for our profession, he left behind him no account of the improvements he introduced into the materials and colours which he used, and more particularly how he perfected the permanence of our wax models. This was largely due to his solitary habits and love of working alone. One of the conditions which he made with Mr. Harrison was, as we have seen, that he should have a room which he could keep locked. This room was in earlier days one that became later the old Materia Medica museum. Later on it was one attached to the Clinical buildings. In either case all that men saw was Towne coming or going, and an old red-capped assistant that looked like an Italian. The way in which Hilton did his share of the work was to devote an hour or two every day to dissecting with the minutest care a very small part—merely one or two inches—of some region on which he was engaged. He then left, and Towne with like accuracy and faithfulness copied those dissections. When it is remembered that this rule was carried on daily all the year round, in days before the present modes of injection and preservation had come into vogue, it speaks volumes for the energy and perseverance of the fellow-workers.

During the later years in which Hilton was Demonstrator of Anatomy he was also associated with Mr. King in making the post-mortem examinations, and in giving demonstrations in Morbid Anatomy. This part of the field at Guy's has been so long occupied by a series of distinguished physicians, that it is interesting to remember, now, how Hilton's tenure of the post influenced his life's work. It is seen in the care with which he unravelled the course of the cerebro-spinal fluid, investigated the causation of hydrocephalus in children, and traced it in many cases to closure of the cerebro-spinal aperture in the roof of the fourth ventricle.

As a Lecturer.

In 1845 or 1846 Hilton was made Lecturer on Anatomy, an appointment which he held till 1853. Anatomy lectures at this time were given six days a week, and at two in the afternoon.

Hilton, as a lecturer, had the art of saying things which had never been said before, the great secret of interesting students, putting the trite and oft-told facts of Anatomy in a totally new light. Words from his lips, "You perceive, gentlemen," or "You observe,' as he pointed to some detail in the relations of the sphenoid, some point in the distribution of the branches of the subclavian, or in the origin or ending of the vagus, was sure to be emphasised by some original remark, not couched in any brilliantly flashing words, but in sober, blunt English, and based on his own observation and his own experience.

We have mentioned Dr. Addison's name: before leaving Hilton as a Lecturer on Anatomy it may be mentioned that that great physician did his surgical colleague honour in a way which is probably quite unique. For many years, when Hilton reached that part of his course relating to the brain, Addison used to attend, a chair being placed for him just within the door by which the lecturer enters from the Museum.

As Surgeon.

We turn now from Hilton as an Anatomist and Teacher of Anatomy to his work as Surgeon and Teacher of Surgery. In 1845 he was elected Assistant Surgeon at Guy's. The surgical staff at this time included Morgan, Key, and Bransby Cooper as surgeons, and Callaway, Cook, and Hilton as assistant surgeons. By this time Hilton had had eighteen years' work in the Medical School. There is an impression in the minds of some that Key disliked Hilton, and kept him back. There is probably some truth in this. From 1830 and onwards Key was the first surgeon of the day; and this, together with the fact that in 1824, only three years after his qualifying, and when only thirty years old, Key had been appointed full Surgeon at Guy's, will account for much of his haughty imperious way, and his habitual self-absorption in the success of his own paths in life. However this may have been, we shall see that Hilton, a little later, could speak very generously of his somewhat arrogant senior. Hilton at once devoted himself to the out-patients. He was well aware that he was behindhand in purely professional knowledge, and this very largely through no fault of his own. During his eighteen years' work at Anatomy and Pathology he had had no care of cases and no opportunity of practical work. At this time, be it remembered, the increasing population of London had not brought about the formation of those smaller hospitals, of which so many exist now, and at which it is possible for juniors to gain valuable experience, while waiting. Hilton's previous work had been almost entirely on purely scientific subjects. And perhaps one other fact should be mentioned if this memoir is to have any of the honesty and straightforwardness which were largely characteristic of its subject. Hilton was not made Assistant Surgeon till 1845. We have seen that the models which we owe to him and to Mr. Towne were finished by 1838. In the years which intervened between the above dates Hilton was, perhaps, a little slack. Some of his early freshness and zeal had passed away with the fruits it bore, for in 1839 he had attained to the high honour of F.R.S. The truth is that certain changes which have taken place in the suburbs will account, in a measure, for any "neglect" of "purely professional work" (Dr. Wilks) for which Hilton himself may have been responsible at that time. He had one or two friends amongst the resident Fellows of that day in Dulwich College. This foundation then consisted of the old three-sided quadrangle, the picture gallery (originally collected for Stanislaus, King of Poland), four resident Fellows, a warden and chaplain; the present Dulwich College School, which did not start in its new buildings until 1870, being represented by Alleyne's original free school. The rising grounds of the surrounding manor, with which everyone is familiar, were at that time richly wooded, instead of being thickly studded with villas. Dulwich was an isolated Surrey village, and there is no doubt that Hilton availed himself a good deal of the privileges which his friends at the College would give him of good dinners and rabbit shooting in the woods around.

However this may be, when appointed Assistant Surgeon, Hilton must have made up for any lost time. Here, too, the scene as well as the actors have been greatly changed. The New Buildings, or Hunt's House, with its north and south wings, did not exist. Out-patients when Hilton was appointed were seen in a wretched room below ground situated on the east side of the two quadrangles through which the colonnade runs, and, being underground, reached by a staircase. The part of the old building now occupied by the surgery and dressers' rooms was then the taking-in room, casualty room, and steward's office.

Hilton had not long to wait as Assistant Surgeon; in 1849 his promotion came to him in a somewhat tragic way. On August 22nd of this year Mr. Key was seized with symptoms pointing to cholera while seeing patients at his house, and he died the next morning, after only twenty hours' illness. Hilton's promotion to the vacancy thus made is announced in the 'Lancet' of September 13th.

Two stories have come to us about this event, the one showing how unexpected was the vacancy, the other the outspoken honesty of Hilton's mind.

Dr. Constantine Holman relates that one day, a few weeks before Mr. Key's death, he, in passing along the colonnade, stopped to pay his respects to his old surgeon, and found him in a state of doubt as to whether he should obey a call to Frankfort to see one of the Rothschilds. The fee was 1000 guineas, but, as Key remarked, he never got up from his table in the morning without having taken ten or fifteen guineas, and these patients would not be missed only once, as many of them would come two or three times. "But what if some one else goes, sir?" "Ay, there's the rub." Key went. Hilton at the time was standing in the colonnade, a few paces off. Dr. Holman said in the course of the conversation, "Mr. Hilton has had a long time to wait for his beds." "Yes, and he will have to wait longer still," was the reply. A few weeks later Key was in his grave in St. Dionis Churchyard, close to the back of his house in St. Helen's Place.

At the first school or staff meeting after the death of Mr. Key, Mr. Dobree, the treasurer (1848—1855), who, like many others, had quarrelled with that most eminent but somewhat dictatorial and arrogant surgeon, simply mentioned his death and his successor, and passed on to other matters. Hilton got up and spoke of the credit which Key had been to the Hospital and School, and then, warming *more suo* at what he considered an injustice, went on to say, "If no more notice than this is to be taken of Mr. Key, all I can say is that it's a d——d shame."

Of Hilton as full Surgeon to Guy's we must try and give a sketch of the man first as a teacher in the wards and the theatre, and then as a lecturer on Clinical Surgery. To realise at all his power as a bed-side teacher, and his habit of getting information out of his cases, my junior readers must understand what a change Surgery has undergone since Hilton passed his twenty years as full Surgeon. Professor Lister had not introduced his great discovery, nor had Mr. Howse, as yet, gone to Edinburgh to return with those primitive and primeval implements of the Antiseptic Surgery of that day,—the putty, the irrigation tins, and the carbolic oil, which, introduced by him in 1870, not without much indifference and some ridicule, and constantly tended and fostered in his hands, have gradually developed into the Antiseptic Surgery as we know it at the present day at Guy's. Hilton's wards were Luke, Charity, and Cornelius—and the bedsteads are about all that have undergone no change. Primary union at that time was the exception, not the rule. Suppuration was not to be described (as by the modern ward clerk) "absent," or as "about a drachm in forty-eight hours," or as "a little sour"; but rather in the words of old Blucher when, after his fall in one of the final charges at Ligny, he had been brought round by copious potations of brandy (intended for use as a liniment rather than as a libation), and excused himself on embracing Sir H. Hardinge with the words, "Ich stinke etwas." The principles of drainage were then in their infancy, and but imperfectly carried out. Any ligature securing a vessel was left with its ends long. Dry lint and strapping were the first dressings; later on, when suppuration set in, linseed poultices, lead and opium lotion, or a red lotion containing tartrate of steel. For fear of secondary hæmorrhage the flaps of a stump were not closed at once, but left to "glaze," and sutured later on in the wards.

The dressership to Hilton was considered as a Blue Riband. In proof of this it is interesting to note that of our present staff the following were his dressers:—Dr. Pye-Smith, Dr. Taylor, Dr. Goodhart, Dr. Savage, Mr. Durham, Mr. Howse, and Mr. Davies-Colley. "Strong men were powerfully attracted by Hilton as a teacher." Dr. A. Buck, of Ryde, writing of his time at Guy's (1863 to 1868) and his dressership to Hilton, says, "Much in surgery has changed, *toto cælo,* since those days. I am not aware, however, of anything that Hilton taught me that has not been useful, or that has become obsolete."

This was due to the fact that Hilton taught on broad lines. He disliked names and conventional descriptions; the information he gave was all based on common-sense and practical observation. His teaching of thirty years ago would have been equally valuable nowadays. There was no conjuring of memories for particular theories; no discussion of useless details and possibilities, only to be forgotten at the next bed; and, above all, no fads.

Hilton relied upon his dressers not only for the treatment, but also for the reports of his cases. The ward clerks, not introduced until 1867, were a novelty that he ignored. The dresser was expected to have the report of each new case that fell to him ready by the time Hilton paid his next visit. If the report showed evidence of common-sense and painstaking observation, words of satisfaction and occasional praise very likely followed. If the reverse, if there was any uncertainty in the dresser's mind as to what he might have observed, if proper names, obscure or theoretical terms were used, rebuke was certain, generally coupled with sarcasm, and, too often, with a sneer. Thus if, in Cornelius Ward, in answer to the question, "What have you got here, sir?" the dresser answered, "I think it's a Pott's fracture, Mr. Hilton," the reply was sure to provoke a storm. Hilton was no respecter of persons. As we have seen, his early education had been faulty, and he had—much too soon to be good for him—been obliged to trust to himself alone. "Vixere fortes ante Agamemnona" was scarcely enough an article of his faith, and the mention of the great St. Bartholomew's surgeon only led to an expression which relegated his name to undeserved obscurity as long as those dressers were in office, while the uncertain tone of the dresser's reply was likely to evoke, "Think so! Do you think that you've hair on your head?" As was natural from the bent of his mind, Hilton was always wanting to know why this or that was done, in marked contradistinction to carrying out any routine treatment. He was most minutely particular as to his cases being dressed properly—a point especially noticeable in his fractures. "Nothing approaching slovenliness escaped his eye, but provoked rebuke mingled with scorn, much dreaded by his dressers. Time after time," writes Dr. Buck, "he made me take down the same fracture, put up, as I thought, with the greatest nicety and care because the patient complained of some pain, at the heel may be, or because Hilton could detect the line of fracture with his finger."

"That fracture is not in good position, sir; will you tell me why?" often fell from Hilton's lips, followed by questions on the origin and insertion of all the muscles concerned, their nerve-supply and grouping.

Much has been said of Hilton's brusque way and rudeness to those with whom he worked—a matter to which we shall refer again.

The following shows that his sarcasm was not always of the cynical and harshly grating kind that it has been represented. We again gladly quote Dr. Buck: "On one occasion, when following him up the grand staircase, I was unconsciously whistling (being

light-hearted in those days), when Hilton, suddenly stopping and parting the press of students following, beckoned me forward, saying at the same time, 'The band always goes in front, gentlemen.' On another occasion he noticed a student going round who was somewhat of a dandy, with an ornamental cane in his hand. Hilton, with much affected interest, requested the youth to let him look at the walking-stick. The owner seemed flattered by such notice, until, after looking it over with much minuteness and admiration, Hilton said, 'Pray, sir, what surgical use do you put this to?' At that time it was not unusual for some students to go round the wards in smart gloves. I remember, once, Hilton was examining a man *per rectum*—a case of fistula or malignant disease, may be—and, withdrawing his finger, he with much courtesy invited these elegantly gloved dandies to examine the case. As they, one by one, withdrew to the rear of the crowd, he said, 'Gentlemen, never miss any opportunity of examining the rectum you get; if you do, you will surely live to regret it.' These words impressed me greatly, and I always acted up to them. Some years after they stood me in good stead. I was newly qualified, and acting as *locum tenens* in private practice, when I was sent for to an old gentleman, very irascible and impatient, whose case I could not readily diagnose. He complained of constant tenesmus and pain in defæcation, which had come on suddenly and recently. fissure, &c. Suddenly Hilton's words crossed my mind, Nothing was to be seen externally, such as piles, 'Never miss an opportunity,' &c. I passed my finger, and found, about two inches up, a large fish-bone jammed transversely across the gut, the removal of which cured the case."

For the following I am indebted to Dr. Savage, who, as is well known, was in the habit of giving Hilton back as good as he gave. "The first time I went round as one of his dressers I had a rose in my button-hole. Hilton merely looked at it. The next time I had a bunch of forget-me-nots. He looked, and said, 'Where did you get them?' I replied, 'From the country.' But the next occasion I had got a big thistle in my button-hole. To this Hilton said. 'Where did you get that? from the country too? I wish to goodness you would take half as much trouble about my cases as you do about your flowers.' I said, 'Tell me one of my cases which is not properly dressed.' He laughed, and admitted that he had no ground for complaint."

We have dwelt at some length on this element in Hilton's life, his brusque bluntness, his ready rebukes, too often sarcastic and irritating, and his too ready betrayal into frequently making jokes at other people's expense—jokes very often grossly personal, and on that account extremely galling. There is no defending or excusing this. Hilton himself, when he was dying, acknowledged this fault, when he felt that it was too late. It will suffice to remark that Hilton's early life, when a man is most impressionable for good or evil, had not been days likely to refine a man or make him considerate of others, and out of these days Hilton had not come unscathed. Very strong in common sense, himself keenly observant and singularly accurate and ingenious in turning his observations into sound practice, he was unsparing at any want of common sense, and prompt to condemn any instance in which a dresser had lost an opportunity of observing for himself, and still more to ridicule any attempt to air a fad, or to quote some unproved and therefore unapproved theory. Too often, in thus condemning and ridiculing, Hilton went too far, and his condemnation and chaff passed into causticity, and his ridicule into rudeness.

But it is fair to add that though much has been heard of the rudeness and the ridicule, too little has been remembered of the approval and the praise which, in a few terse words, Hilton used to bestow on those who showed evidence of painstaking attention to details, shrewdness, and common-sense—points which Hilton, being very strong in them himself, was always glad to recognise in others. We have seen, in Dr. Buck's words, that "strong men were powerfully attracted to Hilton as a teacher:" many of them can speak of instances of Hilton's roughness; but whether it is a prosector who, falling asleep after a morning's hard work during the two o'clock lecture, was waked up with a rap on the head with a femur which lay too ready to Hilton's hand; whether it is an old dresser who, giving an anæsthetic in private for Hilton and becoming too interested in the operation, received at the same time a smack on the face and the rebuke, "Just pay attention to the chloroform, and not to me,"—nearly all the victims (for there were many others) speak without bitterness of the stripes meted out to them; for they feel that Hilton's hand, if heavy, was impartial, and that his readiness with rebuke was intended for the student's good.

As an Operator.

As an operator Hilton was most careful and attentive to details, but in no way distinguished for expertness or skill, or brilliancy in operating. To quote Dr. Buck again, "As an operator Hilton never played to the gallery. He was painstaking and particular, finishing off all carefully, so that it was not often that his cases had to be taken down for secondary hæmorrhage, pain, &c." The bent of Hilton's mind, prone to watch and to observe, and to reason over his observations, was to delay resorting to the knife—a bent no doubt increased by the fact that he had begun his work in days before the introduction of anæsthetics. Hilton had seen that the great rapidity of work which was so necessary in those days had another, and, occasionally, a tragic side. He had, perhaps, been present, with the father of one

of the most justly esteemed of the senior students now with us, when the deft hands of Aston Key, during lithotomy, an operation peculiarly his own, perforated the bladder.

In 1846 Hilton had performed what he believed to be the first recorded instance of any surgeon in this country having succeeded in his attempts to relieve an internal strangulation of the intestine by operation. This case was an extremely interesting one. The patient was a gentleman aged 21, whom Dr. Golding-Bird had seen in consultation, diagnosing strangulation of a loop of small intestine in the right iliac region, not far from the ileo-cæcal valve. This diagnosis was verified later when Hilton operated, and set free a loop of ileum, about six inches long, strangulated in an opening formed by a loop of small intestine, in its turn tied down to the brim of the pelvis by old adhesions, which probably dated from an attack of peritonitis originating "in mesenteric disease" when the patient was three years old. Here, too, the patient sank from acute peritonitis. When it is remembered that abdominal section was performed here without the aid of any anæsthetic—that, owing to the distension of the abdomen (the operation was performed on the fifteenth day of the illness), a prolonged search was required to find the strangulated portion of intestine—that in spite of all these difficulties Hilton succeeded in finding and in completely relieving the obstruction,—we, who operate with all the advantages of the close of the nineteenth century, will do well to remember Hilton's name with respect as one of the earliest pioneers in abdominal section for intestinal obstruction, under difficulties such as we shall never know.

"Rest and Pain."

Before leaving Hilton as a Clinical Teacher, we must refer to his *magnum opus,* his book on Rest and Pain, more exactly called 'A Course of Lectures on the Influence of Mechanical and Physiological Rest in the Treatment of Accidents and Surgical Diseases, and the Diagnostic Value of Pain.' These lectures were delivered at the College of Surgeons in the years 1860, 1861, and 1862. But of this book, one of our very few surgical classics, we shall prefer to quote the words of others. A reviewer in the 'British Medical Journal,' in noticing the second edition, which appeared in 1877, said, "Mr. Hilton's lectures on Rest and Pain are, perhaps, the most considerable contribution to surgical literature furnished by any of the professors of surgery who have occupied the chair at the College of Surgeons since Sir James Paget's celebrated lectures on 'Inflammation and the Healing Process, and on Tumours' were delivered." The same reviewer pointed out as the chief merits of Mr. Hilton's book that it rebuked, and provided an admirable corrective to meddlesome and hasty surgery. Again, it abounds in the ingenious application of the facts of ordinary dissecting-room anatomy to the requirements of daily practice.

Much more lately, in August, 1891, nearly thirteen years after Hilton had been laid in his grave, another voice was raised in praise of the author and his book. Professor Chiene, when giving the Address on Surgery at the meeting of the British Medical Association at Bournemouth, took as his subject "Rest as a therapeutic agent in surgery." The following pithy quotation is some of the highest praise that Hilton has ever had:—"Bacon says there are books to skim over, books to read parts of, books to absorb; Hilton's book on 'Rest and Pain' is one to absorb."

This praise would have been especially gratifying to Hilton, for it is an open secret that the living surgeon who thus reverenced and praised the dead is known at Edinburgh as "honest John."

Hilton resigned his full surgeoncy in 1871, after a tenure of two-and-twenty years. As we have written this account for Guy's men, to recall him to the memory of those who honoured and valued him, and to enable generations who knew him not to form a better idea of the man, as he worked for forty-three years at Guy's, our space does not admit of our following his life beyond the walls of our hospital.

No one would have thought, in looking at Hilton, that he had a great Surgeon before him. He looked much more like a prosperous City man. Short, rather stout and dapper, in a plain, black frock-coat, with faultless shirt-front and linen, a black stock or bow-tie, a fancy waistcoat, festooned with one of the old-fashioned gold chains, very neat, however, and boots with irreproachable blacking—such was Hilton's outer man as he got out of his carriage to enter the colonnade, or as he sat upon one of the beds in his wards examining an inflamed ulcer with a probe, that he might detect the position of the nerves which were exposed in the ulcer.

Public Honours.

Any notice of Hilton, however incomplete, should refer to the fact that certain honours fell to him, unsought, which rarely come, together, to any one Surgeon. He was appointed Surgeon Extraordinary to the Queen. In 1871 the Pathological Society, mindful of Hilton's services in years long gone by in the advancement of sound Pathology, did Hilton and itself honour by electing him President—a compliment especially high, as Hilton, though an original member, had never contributed to the 'Transactions' of the Society. But the highest of these honours was the first; in January, 1839, Hilton was elected a Fellow of the Royal Society. In the paper by which he was recommended as a Fellow he was described as "a distinguished anatomist and lecturer on descriptive anatomy at Guy's Hospital; a gentleman much attached to the sciences of human anatomy and physiology." The actual work specified in the above paper, as done by Hilton was, of course, the two anatomical papers published by him in our 'Reports' for 1837, one on the "Distribution and Probable Function

of the Laryngeal Nerves," the other on the "Sacculus or Pouch in the Human Larynx." Hilton describes this pouch, its position, structure, and capacity, together with the numerous glands supplying it, and the muscles which act upon it; he then discusses the offices which it performs, connected directly and indirectly with the functions of the larynx. In 1838 Hilton contributed a paper to the 'Proceedings of the Royal Society,' on "The Decussation of the Fibres at the Junction of the Medulla spinalis and Medulla oblongata." It is superfluous to add that the only books which he published afterwards, viz., his 'Lectures on the Cranium' and his 'Rest and Pain,' were entirely worthy of the honour which the Society had done him, very early in his career, when only thirty-one.

THE LAST YEARS.

The closing years of Hilton's life were overclouded with increasing distress and suffering, owing to a carcinoma of the stomach, which proved fatal in September, 1878. But those who were much with Hilton at this time noticed that, as he faded, he softened. Many of the characteristics of old days were present almost to the last—the sagacity, the honesty, and the pungency; but the sharpness, the austerity, perhaps we should add the bitterness, were largely gone.

One matter should be mentioned as bearing on what we have said about Hilton's blunt brusqueness, his ready rebukes (too often sarcastic and irritating), and his too easy betrayal into making jokes at other people's expense. He was on his way to Eastbourne—from which he returned quickly, and but a few days before his death—and met Mr. Couling of Brighton. After referring to his illness and fading strength, Hilton said he had been looking backwards, and added, "I know I used to be down upon the men, but I did it for their good." His old dresser and house-surgeon—then, as ever, prompt to cheer and soothe, and to say the kind word—comforted Hilton with the assurance, "I don't believe there is an old dresser of yours that doesn't think of you at least once in the day." "*Do you think so,*" replied the dying man, "upon your honour?"

And now my task is ended. Meagre, unsatisfactory, and far short of my desire as this article is, I trust I have enabled those who knew not JOHN HILTON to think of him as a truly great, because a physiological and scientific Surgeon, and, as a man, as honest and straight as a man can be. My one endeavour has been with a grateful hand to trace, as faithfully as I know how, those personal outlines, and to fix those vanishing traits, which will enable posterity to identify and to individualise the man. A few years ago these dwelt very vividly in the minds of not a few of us, far better qualified than myself to do honour to Hilton's memory. Pass a few more short years, and these outlines, these traits, will have died out of men's remembrance, and, once departed, such things can never be recalled. Whether it is a student in his earlier years, when working at the anatomical models, or one of us of a senior standing, who profit by those teachings by which JOHN HILTON contributed so largely to the more scientific treatment of surgical diseases, we should, one and all at Guy's, honour his name with the words on Wolsey's bust at Christ Church:

NOMEN INTRA HAS ÆDES SEMPER VENERANDUM.

W. H. A. JACOBSON.

Appointments.

Civil.

ROBINSON, W. E., M.D., B.Ch. Oxon., Assistant Physician to Infants' Hospital, Westminster, and Honorary Assistant Anæsthetist to West London Hospital, Hammersmith.

TODD, D. B., M.B., B.Ch., District Medical Officer Kingsbridge Union.

WACHER, SYDNEY, F.R.C.S., Medical Referee under Workmen's Compensation Act, 1906, for County Council, Circuit 49 (Canterbury, Faversham, Ashford, Cranbrook, and Tenterden).

Royal College of Surgeons.

The diploma of Fellow Royal College of Surgeons has been conferred on the following:—

Harold Chapple, M.A., B.C., M.R.C.S., L.R.C.P.

E. L. Martyn Lobb, M.B., B.S., M.R.C.S., L.R.C.P.

University of Cambridge.

Hildred B. Carlyll, M.A., M.B., B.C., kept the act for the degree of Doctor of Medicine on Dec. 15th.

Papers by Guy's Men.

Major J. C. B. Statham, R.A.M.C.: A Small Outbreak of Fever due to Bacteria having Unusual Cultural Character.—*Journal of the Royal Army Medical Corps*, December, 1910.

W. Hale White, M.D., F.R.C.P.: On the Treatment and Prognosis of Exophthalmic Goître. The Purvis Oration, delivered before the West Kent Medico-Chirurgical Society on December 2nd, 1910.—*Lancet*, December 3rd, 1910.

W. Hale White, M.D., F.R.C.P.: Two Clinical Lectures on Typhoid Fever, delivered at Guy's Hospital. Lecture II.—*The Clinical Journal*, December 7th, 1910.

A Case of Streptococcal Urinary Septicæmia.

CLINICAL LECTURE BY Dr. W. HALE WHITE.

Gentlemen,—I want, this afternoon, to consider with you a case which has recently been in John ward, and was of great interest to us. It was that of a boy, æt. 16, who came in on the 16th October, and told us that five weeks ago he was taken with severe headache and rigors, after which he came to the front surgery, and a swab was taken of his throat. He was also given some medicine. Next day he was better, the swab from the throat showed no diphtheria bacilli. But the day after that he was worse again and had another rigor, and a doctor was called in, who ordered him to bed. During the next two weeks he had several rigors and intense headache. Apart from these, he had no symptoms whatever. For a fortnight he was better, and had no rigors, and was allowed up. He felt weak, however, and last Friday, that is to say the 14th, he had diarrhœa and sickness, and another rigor. He was kept in bed. On the 15th he had rigors, and on Sunday, the day of admission, he had two more. So he was brought here. His temperature was found to be 107°, and he was taken in. He had never been jaundiced, never had any pain over the kidneys or ureters, and has never been abroad. Sometimes during the last few days he had had slight pain in the middle of the penis when micturating, and sometimes the pain persisted for a little while after the act. He has never passed any blood in his urine. So the case may be summarised in this way: here was a boy who, on and off for five weeks, had rigors, with a high temperature, and nothing had been discovered to explain them. There were no localising symptoms, and it was only by the closest questioning that we knew he had sometimes pain in the penis. When we examined him, we found the respiratory, circulatory, and alimentary systems all perfectly healthy, and there was nothing wrong to be felt in the rectum. By the time I saw him I learned that for thirty-six hours he had not passed any urine.

The main thing to get hold of in this case as being important was that the boy had passed no urine for thirty-six hours; and in association with this there were the rigors. The first thing that came to our minds was, could it be that he had a stone as the cause of the trouble? That might explain the rigors and the suppression of urine. The way in which it could explain the suppression of urine is that he might have had a calculus in one ureter, and that owing to previous urinary calculi there might have been destruction of the other kidney. There was a case from John in the post-mortem room last Monday week in which one kidney, in consequence of previous stones, was no bigger than a florin. Or there might be in this case a calculus in both ureters. Further, I have known the shock of a stone impacted in one ureter lead to suppression of the urinary secretion of the other kidney. There was a man in the hospital who had a gall-stone impacted in his common duct, and had suppression of urine lasting twenty-four hours. Therefore our first duty was to X-ray this boy, but we could not find any evidence of stone at all. Meanwhile he had passed a few ounces of urine, and then we were able to get to work on the second suggestion, which was that he had some micro-organisms, almost certainly bacillus coli, in his urine, that bacilluria due to that organism accounted for the rigors, the temperature, and the suppression. But it did not seem likely that that was the correct view, because the boy had so few urinary symptoms: no casts, no blood, no pus, no increased frequency, and no pain. It was arranged, as perhaps the X-rays had failed to find a stone, that Mr. Steward should cystoscope him to see whether, after giving him methylene blue, stained urine came down both ureters properly. But on the morning that it was arranged that he should be cystoscoped we learnt that the boy had had another rigor the previous night, and had passed more urine. Therefore, as people who have had rigors bear instrumental examination of the bladder badly, it was deferred. But on the afternoon of the day he was to be cystoscoped we got the bacteriological report on the urine, which says, "The centrifugalised deposit of this urine revealed the presence of a pure emulsion of streptococci; no pus cells, casts, crystals, or blood." We thought we were now on the right track, only we were very surprised that the organism was not the bacillus coli.

The subsequent history of the case is quickly summed up. The boy was given antistreptococcic serum, 20 cc., the same day on which the condition of the urine was found, and he had two subsequent injections of 20 cc. each. A serum rash appeared, but he got well and went out of the hospital. When discharged the urine was free from any micro-organisms. When we found the streptococci in the urine we naturally began to look for the primary source. His nose

Chart Illustrating Dr. Hale White's Lecture on a Case of Streptococcal Urinary Septicaemia.

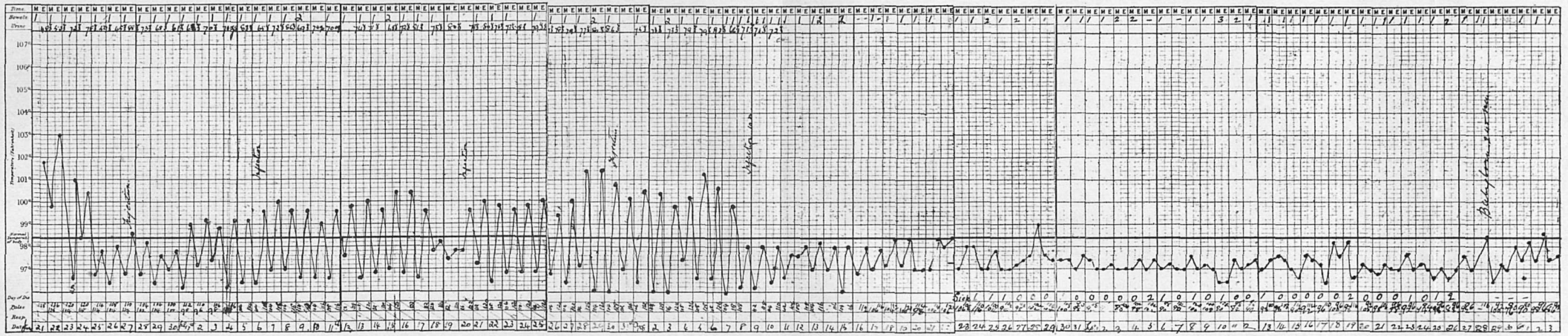


Chart of Patient confined September 28th, showing raised temperature from June 21st to August 9th; normal temperature from then to confinement, and dates of giving vaccines.

did not look quite healthy, and it might possibly have been the source of infection, so it was syringed out with an antiseptic lotion, but from its appearance I think it is very unlikely that it was the source of infection. There was a slightly dull patch at the base of one lung, and we thought it just possible there might be empyæma, but there was no pus there. So we must leave the question of the source of infection by these streptococci unsolved. That is not altogether surprising, because in many cases of malignant endocarditis we do not find the cause of the infection. His temperature chart, which I show you, does not indicate how ill he has been, because the majority of rises of temperature occurred whilst he was outside the hospital. The first rise on the chart is that of 107° in the surgery, but by the time he came into the ward it had fallen to 103°. Two days afterwards he had another rigor with rise of temperature, and next day he had one, and the next day one. Then the temperature kept normal until he went out.

These cases are very interesting, and I thought I would go over with you some points about them. It is only of late years that we have discovered their existence, and an account of them has hardly yet crept into the books. You know that micro-organisms (*e.g.*, those of tubercle or typhoid) may easily pass from the blood into the urine. So it is not surprising that micro-organisms should be found in the urine. Experimentally, if you inject coli organisms, or anthrax organisms, into the blood of an animal you can quickly recover them from the urine. The kidney is one of the channels by which the body gets rid of micro-organisms existing in the blood. The commonest by far are the coli, but with regard to them some authorities believe that they pass through the wall of such of the intestines as lie on the kidney, and so straight into the renal pelvis; others consider that in young female children they get into the urethra from soiled napkins. I have got several cases to relate to you this afternoon, and the one I began the lecture with is the only one in which the organism has not been the bacillus coli. Occasionally there are streptococci, and occasionally the organisms are staphylococci. I want you to remember two things about these cases. In the first place, they are very often overlooked, because there may be no symptoms referable to the urinary tract. It requires some enthusiasm to put the patient to the expense and to take the trouble of a complete bacteriological examination of the urine when there is no symptom pointing to urinary affection. Think of the case I have just related; the boy was so ill that he had gone on for five weeks with rigors, and a temperature which reached 107°. There was no albumen, blood casts or pus in the urine to show the presence of these micro-organisms. So remember you are very likely to overlook these cases if you do not, in all cases in which the cause of pyrexia is very obscure, examine the urine bacteriologically, so that the labours of the clinical physician and bacteriologist are considerably increased in connection with these cases. Only a few days ago I saw a woman who complained of rises of temperature twice a week, up to 103° or 104°, and next day she was all right. Nothing can be found wrong by any physical examination, nor does the urine contain blood, or pus, or casts. It is quite likely that when we have obtained a catheter specimen of the urine in a sterile bottle, we shall find that she has bacilluria. There are other cases in which you find changes in the urine, pus and blood in particular, and sometimes casts. There is a boy in the ward recovering from typhoid fever. He had pus and blood in his urine, and we thought he might have a stone in his bladder, but the X-rays negatived this view. The symptoms cleared up in a few days before we examined his urine bacteriologically. There is considerable probability that he was suffering from some form of bacilluria. Cases in which the urinary symptoms are the most obvious are very liable to be mistaken for some local trouble, usually stone. The reason for that we shall see directly. Of course you frequently find two sets of symptoms combined: severe urinary symptoms, and severe general symptoms.

Now to tell you something about the whole group of cases. These cases of coli infection of the urine are much commoner in women than in men; and they are much commoner in pregnant women than in other women. The reason for that is obscure, but it is thought to depend in some way on the pressure of the uterus on the ureters. Not only are these cases common in pregnant women, but they are not infrequent after operations on the rectum, when of course it is very likely that the ureters will be pressed upon or damaged where they enter the base of the bladder. Why pressure on the ureters should lead to the trouble is not very clear, even if we side with those who think that the micro-organisms are taken up by the blood from the intestine and carried by it to the kidneys and so excreted in the urine. For some reason the trouble is commoner on the right kidney than the left in pregnant women; and

those who attach great importance to the uterus pressing on the ureter and rendering bacilluria possible should try to ascertain whether the pregnant uterus presses more on the right ureter than on the left. Some, as I have told you, believe that the colon bacilli pass directly from the intestine to the urinary tract; they would say that the rectal operations and the pregnancy made the passage of the bacilli easy.

I thought the best way to study the disease would be to give you several cases of it. I have been trying to remember the cases I have seen this year; and already this year I must have seen ten or twelve of them. Within two months we had three in Mary ward, so they are not rare. Here is one which shows you the importance of being on the look-out for the condition. The patient was a woman aged 45, who, five weeks before I first saw her, complained of swellings in many of her joints. Remedies for gout were tried, but did not relieve her. The ears and the bridge of the nose became swollen, and double conjunctivitis supervened, followed at the end of four weeks by, I am told, severe cystitis with pus in the urine, high temperature, pain over the bladder and both kidneys. The various doctors who saw her said she had gouty cystitis, and when I saw her she was very ill with cystitis and double pyelitis; she was vomiting, she had a rapid pulse and a high temperature, and I think everyone who saw the case thought she would die. We isolated the bacillus coli from the urine, and an autogenous vaccine was prepared; her opsonic index to this bacillus was only 0.35. She had a five million dose, which was followed by a rise of the index to 1.6. Four days later she had a thirty million dose, and several days later two hundred and fifty million. Improvement occurred after the first injection, she made an uninterrupted recovery, and a year later, when last I heard of her, she was perfectly well The moment we examined her urine we got on to the track of the condition, and there is no doubt her life was saved thereby.

Here is another case. A young man, aged 26, was seen on March 18th, 1909. He had enteric fever from Xmas, 1908, to February, 1909. On February 25th the temperature was normal, but then it began to get high in the evening and low in the morning, temperatures suggestive of pus. On the 15th of March pus appeared in the urine, and the right kidney became tender. The bacillus coli communis and the staphylococcus albus were found in the urine, vaccines for which were prepared. He was given a dose of five millions of coli vaccine on the 20th of March, and on the 23rd his temperature had become normal, although previously it had been raised for three weeks. He had another dose of five million, and got perfectly well. He had one more injection of bacillus coli, and gained weight, and was very well indeed. Before we examined the urine bacteriologically it had been intended to explore the right kidney, because it was thought to have an abscess in it. Fortunately the examination of the urine saved the patient from that unnecessary operation.

Here is one of the first cases recognised at Guy's. The patient was in the hospital in 1905. She was aged 30, and she came to the out-patient department on account of pain in the right side associated with pregnancy. She had had six other confinements, but no trouble with any of them. She was seized on October 13th with shivering and sudden pain on the right side. The suddenness of the onset is very striking in many of these cases. She came up to Mr. Bellingham-Smith's out-patients, and he found that the uterus reached half an inch above the umbilicus, the temperature was 101·8°, and there was pain in the right loin extending round to the front of the abdomen and down the right iliac region, and tenderness over the right kidney. There was a trace of albumen, but no pus or blood. She came in under my care into clinical ward, and was put upon milk diet, and warmth to relieve the pain, and urotropine. A catheter specimen of the urine showed a pure culture of bacillus coli communis; she gradually got better, and left the hospital well.

Another case which comes to my mind is that of a doctor's wife, whose case received much thought from her husband and the doctor who was called in to see her. She had pyrexia, which she attributed to influenza, and soon the urine contained blood. Then it was thought she might have acute Bright's disease. But that did not seem tenable for long. She had some pain in the loins, but not much; there was no œdema, and the temperature remained at a high level. To make a long story short, a culture was made from her urine, and a pure culture of bacillus coli communis was found, and she was vaccinated. She began to improve at once, although she had been ill for weeks beforehand, and she is now perfectly well, and walking about.

Now take some cases which have recently been in the wards. As I have said, in two months there were three cases in Mary ward.

One complained of pain in the loins, with some frequency of micturition. A very mild case in regard to general symptoms, and, in fact, no urinary symptoms beyond the frequency of micturition and the pain in the loins; there was no pus or albumen. The urine was examined, and pure cultures of the bacillus coli communis were found; she was vaccinated and got well. She had urotropine. The other two cases have been rather more severe. Here is one which I have brought the notes of; a comparatively slight case, but not quite so slight as the last. On Friday, August 15th, a woman, æt. 42, was taken ill with sudden stabbing pain on the right side, acute in its onset. The pain was aching in character, and continued with more or less severity until August 19th, when she came to the hospital, and was admitted next day. She had never been sick, the pain did not radiate, she had had no rigors, no frequency of or painful micturition, and she never had any rise of temperature. The diagnosis of pyelitis was made, and bacteriological examination of the urine showed it to contain bacillus coli communis. The pain left her some days after admission; she had one injection of a vaccine, and was discharged feeling quite well. There is a case with no general symptoms, no rise of temperature, and very few symptoms indeed.

Here is another case, rather more severe, also from Mary ward recently. She was a woman æt. 19, who was admitted on 11th August this year. She is married, and had one child. She was six months pregnant. On Sunday, 10th July, she had an attack of diarrhœa lasting all day, and on Monday at 8.30 p.m., when at work, was suddenly seized with acute pains in the abdomen, especially in the epigastrium, and on the right side. This case was of interest, because you will notice that she had some diarrhœa, and that suggests that possibly the diarrhœa was either caused by or led to some solution of the mucous membrane of the intestine, so that the colon bacilli were able to get into the blood. She was doubled up with pain at the time, and had to be taken from her work, and she was admitted at once. Lately she has had frequency of micturition, especially at night, having to get up two or three times. This had occurred for the last two or three months. The picture in the report shows very well the area of the pain and tenderness She was tender over the right kidney and down the right ureter, and over the back she is tender over the right renal region. She gradually got all right. The urine contained minute traces of pus and plenty of bacillus coli communis. She was treated with several doses of vaccine and urotropine, and she got well and went out. Hers was a more severe case than the others. Her temperature was raised for the first week she was in the hospital, and was sometimes as high as 103°. It was up every evening and down every morning.

Here I have a still better chart—it is reproduced in this lecture—which I am able to show you, owing to the kindness of Dr. Percival White. The patient, a woman, was confined on 28th of September this year. She was first seen on 21st of June, about the seventh month of pregnancy. She had pains in the loins, and fever. She had a hæmic murmur, and that had led one physician to the diagnosis of malignant endocarditis. However, subsequently it seemed probable that the murmur was hæmic, and that another explanation must be found for her condition. Bearing in mind the frequency of coli infection in pregnancy, we examined her urine, and got a pure culture of bacillus coli. She had altogether five injections of autogenous coli vaccine. It was not until after the fifth injection that the temperature became normal. She also had full doses of urotropine. I show you her chart, which is typical of a severe case—the temperature up every evening and down every morning, lasting from June 21st till August 9th. She has got well, was confined at full term, and went through her confinement normally, and the child was healthy.

You will have gathered from what I have told you that there are two groups of symptoms—the general and the local. The most characteristic of the general symptoms are the raised temperature and the rigors. As you will have seen by the charts I showed you, the temperature makes great excursions in a short time. Remember that the case which forms the subject of this lecture had a temperature of 107° in the surgery, yet within twelve hours the temperature was normal; in fact, these temperatures are not unlike those of ague. Not only does it go down suddenly, but it goes up suddenly. And the patients are not nearly as exhausted by these ranges of temperature as you would expect. The woman whom I mentioned to you had a temperature from June 21st to August 9th, yet she lay comfortably in bed and took her food, and there did not seem to be much the matter with her. These patients complain of weakness, but they have not that exhausted poisoned look that an ordinary case of septicæmia would have with such a temperature. This was, for example, true of the doctor's wife; she complained of great weak-

ness, but did not look ill in the same way as she would have done had her temperature been caused by an ordinary septicæmia. The pulse and respirations are raised only in proportion to the temperature. In a few cases there are no general symptoms. One of the women complained only of pain in the loins and frequency of micturition, but there were no general symptoms. You will find that some of the cases of nocturnal incontinence in children are due to the presence of bacilli in the urine.

Now we come to the local symptoms. The most striking in every case I have related to you, except the boy, whose case I am lecturing upon, is pain and tenderness in the kidney, usually the right kidney. Sometimes both pain and tenderness extend down the ureter, and both get worse and worse as the case goes on; and finally there may be in a severe case pain and tenderness over the bladder. I want you to remember that cystitis is not a prominent feature of these cases. The patient herself often thinks she has inflammation of the bladder because she sees pus in the urine, but as a rule they are cases of pyelitis, not cystitis. Cystitis is only present late in these cases.

You will have gathered from what I have related that frequent micturition is a common symptom, and in some there is scanty urine. That was strikingly so in the boy, for he had complete suppression for thirty-six hours. Sometimes ordinary examination does not reveal anything wrong with the urine, and that was so with our boy. If there is anything wrong, it is most likely to be a trace of albumen, sometimes blood, sometimes pus. Pyuria, if present, often persists after the temperature has become normal, and often the micro-organisms persist in the urine for some time. They are still present in the urine of that pregnant woman who was confined in September. It has been stated that the presence of bacillus coli in the urine leads to abortion when the woman is pregnant, but that is very rare. People have said it does because they imagined it would. The labour usually goes on to full term, as in the case I have related, the confinement is natural, and the disease does not seem to affect the child. Usually the symptoms of the coli infection of the urine subside before the confinement takes place, and that was so in the very long case just related. The coli symptoms subsided on August 9th, and the confinement took place on September 28th.

The prognosis, you will have gathered, is usually good. I have not personally had a single fatal case. Even the boy in John ward is well.

You may ask me, should you induce labour for this trouble? Virtually, never. If in the severe case just related the symptoms of bacilluria subsided six weeks from the end of the pregnancy, and the patient was delivered of a healthy child, with a normal confinement, it is unlikely that you will come across a case in which you need to induce premature labour.

It has sometimes been urged that you should cut down upon the kidneys, as pyelitis is present. I have never known any case severe enough for that. In one of the cases I mentioned it was proposed to do so, but treatment of the patient with vaccines and urotropine prevented the necessity for it. So you may say there are few diseases in which the prognosis is better than it is in this.

The last point is the treatment, and that, happily, is very simple. You give the patient bland drinks—barley water, milk, and so on—and a simple farinaceous diet. But the chief part of the treatment is the administration of urotropine and vaccines. There are no cases which do better with vaccines, as far as my experience goes, than these. This is easy for you to remember, because the next most successful disease to be treated with vaccines is gonorrhœa, which is a genito-urinary disease. Two, three, four, or five injections with an autogenous vaccine will usually suffice. The exact dose will depend on how severely ill the patient is. If she is very severely ill, five millions is a safe dose; if not so ill, ten millions, future doses being determined by the condition of the patient. You should also give urotropine, or one of the many derivatives of it which are on the market. It seems to keep the growth of the micro-organisms in check, and under such treatment these patients will nearly always get well. One thing that you must not do is to wash out the bladder. These patients have not often got cystitis, and so it is not usually needed. Washing out the bladder is only justifiable in the rare and severe cases in which there is considerable cystitis. Suppression of urine is best treated by frequent copious draughts of hot tea.

Change of Address.

C. C. Holman, M.A., M.B., B.C., from Leicester Infirmary, Leicester, to 3, Park Road, Bexhill-on-Sea.

G. Turner, M.B., from Auchinclech Cottage, Skene, Aberdeen, to the High Street, Colyton, Devon.

(The Editor will be very glad to receive a postcard with notes of any change of address.)

Guy's Hospital Physiological Society.

A MEETING of the Society was held on Monday, November 28th, in Class-room 2, at 4 p.m. Mr. Hughes occupied the chair, and 57 members were present. An interesting paper was read by Mr. Stephenson on "Hypnotism."

A brief description was first given of the methods used by doctors who practise hypnotism. The passes employed by Mesmer do not exert any mysterious influence, but are merely a means of producing that concentration of the mind which is a feature of all methods. If willing, the healthy and strong-minded are the easiest to hypnotise. There are three stages of hypnosis, the two later being characterised by no post-hypnotic memory, and the third by the possibility of post-hypnotic influence. The condition tends to terminate spontaneously. Examples were given of experiments performed during hypnosis which show an increased control of the mind over physical and sensory processes, such as the production of pathological changes and anæsthesia. Hypnosis is not sleep, since the subject is conscious of his surroundings, and if re-hypnotised remembers all that occurred during previous hypnosis. Mesmer explained the phenomena of hypnotism by the passage of a fluid from the operator to the subject, and Heidenhain by the inhibition of the higher centres. The theory held to-day is that they can be explained by the existence of a dual consciousness, the subconscious mind having for some reason become extremely responsive to suggestion. Everyday incidents were given to support the existence of a subconscious mind, which is claimed to be the seat of the highest mental activities. When in hypnosis a person does not surrender his will to the operator; the predominant features of his character still exert their influence.

The most valuable aspect of hypnotism is its application to the treatment of mental diseases. Suggestive treatment is the struggle for existence between the existing morbid ideas and those of a healthy nature suggested by the operator. The object of hypnotism is to make the patient consider suggestions which he would ignore in the normal state.

An ordinary meeting of the Society was held on Monday, December 5th, in Class-room 2, at 4 p.m., Dr. Cameron occupied the chair, and 38 members were present. An interesting paper was read by Mr. York-Moore entitled "Instinct."

He explained that instincts were congenital, adaptive, and co-ordinated activities involving the behaviour of the organism as a whole, and were relatively complex. In this way they were to be distinguished from mere reflex actions, which were more simple. They were not characteristic of individuals, but were similarly performed by all similar members of the same group, under circumstances which took place frequently, or were vitally essential to the continuation of the race. They were more or less constant, but subject to such variation as that found in organic structures. They were to be distinguished from habits, which were entirely due to individual acquisition and repetition of individual performance.

Instances of true instinct were given in such acts as mating, for the continuation of the species, nest building, and migration.

For examples of less general instincts, there was that of the young cuckoo, which, directly it was hatched, turned the other newly-hatched birds, and any eggs that were left, out of the nest. The squirrel quite instinctively buried its nuts whenever it had more than was necessary at the time.

The pecking of a chick at anything it saw, taken as a simple example of instinct, which was not found in the young ostrich, showed how instinct acted. The stimulus given by seeing the object gave rise to a commotion in the lower brain centres, or in some cases those of the spinal cord, such as to cause the automatic distribution of outgoing currents, along efferent nerves, to the special motor organs concerned in pecking. These outgoing currents were so delicately ordered and graded in intensity as to produce just the particular movements required. The motor co-ordination was, therefore, inherited. So much for congenital instinct.

Acquired instinct could be obtained through experience, imitation, tradition, and generally a mixture of one with another of the three. Under this heading came such instincts as an animal's knowledge of what to eat, their fear of an enemy, the singing of birds, and avoidance of such dangers as telegraph wires. The young chick gave a good example of the first. If nice and nasty tasting caterpillars were thrown to it, it could not distinguish between them until it had tasted. But after once tasting, the stimulus that the sight of the nasty tasting one gave it would keep it from eating that kind again.

As an example of the influence of imitation, we might instance the well-known fact that when one in a company looked at his watch, others frequently did the same, sometimes quite unnecessarily.

For examples of "tradition," it seemed likely that the way beavers performed their wonderful works was due to "tradition." Also when a young chick for the first time saw a cat it showed no fear until it heard the danger note of the hen.

Acquired instincts were not handed down to the young as a congenital instinct. If they had been, the young ostrich would have been expected to peck at its food, but it did not do so, as was seen with regard to incubated ostrich's eggs, unless some stimulation, such as an example for imitation, was given to it.

Variations and varieties of instincts were obtained by means of natural selection.

H. W. EVANS, Hon. Sec.

Guy's Hospital Musical Society.

THE choral and orchestral sections of the above society gave a combined concert in the Physiological Theatre on Tuesday, December 13th. The two sections collaborated in the first item on the programme—a performance of C. H. H. Parry's choric song, "The Lotus Eaters." In this work the composer has caught the spirit of Tennyson's words in a delightful manner, and the music is of a most descriptive character throughout. It is a very ambitious work for such an occasion, and therefore a finished performance could hardly be expected, but taking into consideration the difficulties of the work, it was on the whole an excellent performance. The leads were noticeably good, and the quality of the tone was generally good, but in the unaccompanied parts the chorus, especially the tenors, were inclined to get flat. It was without doubt owing to the inspiring guidance of their conductor, Mr. Clive Carey, that the chorus and orchestra acquitted themselves so well, and we congratulate Mr. Carey on the good results of his untiring efforts. Praise must also be given to Nurses Miller and Fletcher, to whom the solos were entrusted.

Then followed two unaccompanied part-songs for chorus alone—namely, "Corydon Arise," by C. V. Stanford, and "Since thou, O fondest," by C. H. H. Parry. Of these, the second was by far the better performance, and purity of tone was particularly noticeable here.

This was followed by the first performance of a delightful suite by A. L. Gardner, admirably played by the orchestra under Dr. Eason's bâton, the composer playing the piano part. The suite is in three parts, and opens with a Prelude, which held the attention of the audience from the beginning, for not only has it a melody possessing both beauty and refinement, but it has a special charm of romance which appeals strongly to the listener. The composer has chosen a fugue, or, as he has modestly named it, a "fughetta," for the next movement. This opens with a very effective subject for the 'cellos, which is elaborated with much skill. The composer then shows that he is equally skilful in a lighter mood, and the suite ends with an animated humoresque, which was played with such spirit that it evoked prolonged applause from the audience. The suite is very effectively written for a small orchestra, and we heartily congratulate Mr. Gardner, who well deserved the enthusiastic reception that was given him.

The first half of the programme ended with three Cavalier songs, by C. V. Stanford, admirably sung by Mr. L. C. Dundas Irvine and a male chorus. They are exceedingly spirited songs, demanding much energy and vigour from the soloist, and it is needless to say that Mr. Irvine supplied both these qualities.

The second half opened with the slow movement of Max Bruch's Violin Concerto in G minor, Mr. Loos being heard in the solo part. It is a movement of deep musical beauty, and was played well by both soloist and orchestra. The time was dragged here and there, and the intonation of the orchestra was not by any means faultless, but one felt that it was a sincere rendering of a beautiful work.

Nurse Millar then gave an expressive rendering of Saint-Saens' "Softly wakes my heart," from "Samson and Delilah." The quality of her voice is rich and sympathetic, and she sings with evident enjoyment and keen musical insight. The audience much enjoyed her song and enthusiastically called for an encore, for which she gave an attractive little Irish song.

The orchestra then played a Valse, by Tschaikowski. The swinging melody with which it opens was given very feelingly by the first violins, and was taken up with much spirit by the other instruments, and all who heard it were charmed with the grace of the performance. This was followed by a most effective piece, by Komzak, entitled, "Märchen," which the orchestra played to perfection, showing admirably the contrast between the solemn opening and the bright rhythmic melody that follows. The enthusiastic demand for an encore was inevitable.

Two trios for female voices only were then given. The first, entitled, "The Snow," by Sir Edward Elgar, was very artistically rendered, and the nurses deserve special praise for the charming way in which they sang "Orpheus with his Lute," by Edward German.

The programme ended with a vigorous rendering of a Concerto, by Bach. It is an exacting work, which demands great precision in all the parts, and the players found it difficult at times to restrain themselves, but their attack was always good, and the way in which the subject was given by the various instruments was very convincing.

The concert as a whole was very successful, and reflects great credit on all who took part in it. Especially we must mention the admirable conductorship of Mr. Clive Carey and of Mr. H. L. Eason, who directed the choral and orchestral items respectively. We regret to hear that Nurse Rees, the Society's talented accompanist, was prevented by illness from taking her part in the concert. At short notice, Miss W. Gardiner very kindly undertook this important task, and carried it out with complete success.

It is pleasant to be able to add that there was a much better audience than is usual on these occasions. We shall look forward to the Society's next concert.

THE EDITOR will, at all times, be glad to consider Articles or sketches, provided that they are accompanied by the writer's name and address, not necessarily for publication. Payment is a matter of arrangement, and the fees that the GAZETTE *can offer are merely nominal, but if the writer desires any remuneration that fact should be stated. Authors who desire reprints of their papers should make their own arrangements with the printers when they return their proofs.*

Medico-Chirurgical Antics.

The Staff Caught Unbending.

[For the accuracy of the following report which has reached us we accept no responsibility.—Ed., G.H.G.]

An unprecedented event has recently taken place. Fired with enthusiasm by the prevalence of ward concerts at this time of the year, the staff decided to unite their multiple talents and to give a conjoint concert. The proceedings were opened by a trumpet solo, admirably executed by Dr. Hurts; and to see him openly blowing his own instrument was a sight as attractive as it was extraordinary. This was followed by a series of recitations by Mr. Leyne, delivered from a very novel position, namely, the edge of an operating table. His first sounded in some way *familiar, beginning:*—

"Murmur not appendicitis,
All things are not what you think;
For, if my opinion right is,
You've an intestinal kink!"

This elicited a good deal of applause, mingled with which could be heard the familiar rah! rah! rah! of a party of Americans who had taken a box for the occasion. Mr. Leyne, remarking that he would tell them something that was not in the books, then gave a piece of his own, the first verse of which was:—

"The boy stood by the broken bone,
Whence all but he had fled,
With little plate and screws alone
I'll make it hold he said."

When the excitement had subsided, it was announced that the Guy's Harmony Quartette would appear, and accordingly Sir Cowper Perrigh, Dr. Jawd-on, Mr. Leyne and Dr. Hurts took the stage in a touching little madrigal, entitled "Love one another." The next item was an extract from "The light that failed," by Mr. Tschentunn, who gave as an encore that popular piece "The Wreck of the Wetforus." (Shouts of "We're here, we're here!") Mr. Turnher was the next performer, singing "Always merry and bright" with great vivacity. Dr. Pembrigh had been put down for a comic patter song, but having unfortunately left his words at home, was persuaded to give a lecture instead, none of the audience noticing the difference.

The *pièce de resistance* of the evening was, however, a Salomé dance by Earl Alfred, whose dress of a string of ducal appendices was voted most fetching by all present. Unfortunately he could not give an encore, having "to rush off, you fellows, you know," to attend the Prince of the Nuttes who had been taken ill. Dr. Buoykotte gave "Down among the dead men," accompanied on the bones by Bell; and, being encored, sent on Dr. Guidhyrt as a deputy, who sang "I'm following in father's footsteps" with good effect. Dr. Higher next exhibited his troupe of trained Trypanosomes, and the serpentine dance of his vivacious vibrio aroused much emotion. "Hurrah for the catheter life" by Mr. Tompzonne, and that well-known oration, "Friends, patients, countrymen, lend me your ears," by Mr. Mollyson concluded the first half of the programme. During the interval, the artists took tea with divers sisters, and the re-start had to be considerably delayed awaiting the return of Mr. Steughard.

The second half of the programme consisted of an Historical Pageant, especially written for the occasion by Mr. Sighmonds, who remembered so well what happened in 41, 2, 3, 4, assisted by Dr. Rypman, that expert pageanteer. Mr. Leyne, as Willie the Conqueror, was alternately inaudibly excellent and excellently inaudible, while Mr. Roelands, as the first Prince of Wales, captivated all hearts; his song and flat-foot dance "I'm Bobbie from Wales, yes indeed that I am" being voted very novel. Dr. Fourcet made a good honest John, his worried expression when called upon to sign the Magna Carta, and his "Well of course it *might* be," when told it was for England's good, showing much histrionic talent. Dr. Pyt was the Earl of Chatham, but we think had not studied his prototype sufficiently, for, after his last speech (cheers, hastily suppressed) on American Treatment, instead of dying himself, he reduced his audience to wishing that they were. A Tableaux of the Stony Age, by the Junior Staff, was an æsthetic effect produced by Mr. Roughell. (The weapons used in this picture were supplied by Coles.) Earl Alfred, who had by this time returned, "took the cake" in his well-known way, his song:—

"I am Alfred, always late,
I am Alfred called the Great,
My famous feats in surgery
Will make a page in history,"

being especially copied (without permission) from the Follies. A panic was narrowly averted at this stage of the proceedings. Witless, who acted as usher, shouted silence, and everyone present, thinking his name had been called, rushed to the doors. Order was restored by Dr. Pyt beginning to lecture, which sent everybody to sleep, statim. Mr. Targhett, who played Henry 5th, delivered his one line," "Once more unto the breech, dear friends," with much gusto, and without instruments.

Of the smaller parts, Mr. Finnymoor made a splendid Hugh le Dispenser, while Mr. Moretun, as Henry the Seventh's Cardinal, seemed able to draw sparks from a stone. All present voted the evening a great success, and the proceedings terminated with a vote of thanks to those members of the staff who had not taken part, for not having done so.

SANITAS.

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

Testimonial to Miss Newton.

DEAR SIR,—We are confident that every Guy's man, who has ever been in residence in the College, and everyone who has been in the "Rooms" at any time since 1877, cherishes the kindest remembrances of Miss Newton, and will be anxious personally to give tangible expression to the affection and regard in which she is universally held.

Miss Newton will shortly retire after thirty years' devoted service with a pension from the Hospital and Medical School, which she had hoped to supplement with her own savings.

It has, however, come to our knowledge that the failure of the Charing Cross Bank has swept away all that she had been able to put aside for her retirement. Instead, therefore, of making her a presentation such as would have been suitable under happier circumstances, it is proposed to ask her large family of "old boys" to join together in subscribing a substantial sum which will make up for her loss, and shall enable her for the remainder of her days to enjoy a fair measure of the happiness and comfort which throughout her life she has so unselfishly provided for others.

We regard ourselves as fortunate in having had this opportunity of signing a letter commending to our colleagues this project which we are sure will meet with universal approbation.

Subscriptions will be gratefully acknowledged by Mr. C. H. Wells, Guy's Hospital, London Bridge, S.E.—Yours faithfully,

W. Hale White, *Senior Physician.*
C. J. Symonds, *Senior Surgeon.*
E. C. Perry, L. A. Dunn, H. L. Eason — *Past Wardens of the College.*
W. M. Mollison, *Present Warden of the College.*

Alfred Allport, Henry Blatherwick, A. R. Brailey, P. W. L. Camps, W. W. Cook, Harry Cooper, Francis G. Cross, Edward Fisk, Bryden Glendining, W. E. Hills, E. E. B. Landon, Lawrie McGavin, Arthur Miller, Charles D. Muspratt, John P. Pendlebury, R. M. Henry Randell, Charles F. Routh, E. W. Sheaf, Trevor Shorland, Gerald Sichel, T. P. Thomas, Wilson Tyson, Sidney Wacher — *Vice Presidents of the Guy's Hospital Biennial Dinners,* 1908 *and* 1910.

MISS NEWTON TESTIMONIAL.

PRELIMINARY LIST OF DONATIONS.

	£	s.	d.
Sir Cooper Perry, M.D.	25	0	0
Sir Alfred Fripp, M.S.	25	0	0
Anonymous	25	0	0
W. Hale White, Esq., M.D.	25	0	0
Robert Gordon, Esq.	10	0	0
John Fawcett, Esq., M.D.	10	0	0
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W. A. Lane, Esq., M.S.	10	0	0
The Residents, Dec., 1910	10	0	0
L. H. McGavin, Esq., F.R.C.S. ...	5	5	0
C. J. Symonds, Esq., M.S.	5	0	0
A. F. Hertz, Esq., M.D.	5	0	0
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F. E. Fremantle, Esq., M.Ch. ...	5	0	0
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W. M. Mollison, Esq., M.C.	3	3	0
Maurice Craig, Esq., M.D.	3	3	0
W. E. Hills, Esq.	3	3	0
J. W. H. Eyre, Esq., M.D.	2	10	0
A. Allport, Esq.	2	2	0
W. W. Cook, Esq.	2	2	0
F. G. Cross, Esq., F.R.C.S.	2	2	0
R. M. H. Randell, Esq., M.D. ...	2	2	0
J. A. Reaside, Esq.	2	2	0
C. F. Routh, Esq., M.D.	2	2	0
A. Neville Cox, Esq.	1	1	0
H. Blatherwick, Esq.	1	1	0
H. Cooper, Esq., M.D.	1	1	0
P. W. L. Camps, Esq., F.R.C.S. ...	1	1	0
A. A. Miller, Esq., M.D.	1	1	0
E. Fisk, Esq., M.D.	1	1	0
C. D. Muspratt, Esq., M.D. ...	1	1	0
S. Wacher, Esq., F.R.C.S.	1	1	0
G. Sichel, Esq., F.R.C.S.	1	1	0
T. P. Thomas, Esq.	1	1	0
J. P. Pendlebury, Esq.	1	1	0
A. R. Brailey, Esq., M.C.	1	1	0
B. Glendining, Esq., M.S.	1	1	0
W. Tyson, Esq., M.D.	1	1	0
E. E. B. Landon, Esq.	1	1	0
T. Shorland, Esq.	1	0	0
W. J. Curry, Esq.	0	10	6
T. B. Layton, Esq.	0	10	6
E. G. Schlesinger, Esq.	0	10	6
E. W. Sheaf, Esq., M.C.	0	10	6

The Guyite Club.

SIR,—I have read with much interest the notice in your paper of the Guyite Club, to which I belonged, contributed by Dr. Blatherwick. The account is pretty correct, but you will allow me to add a few more particulars. In the first place, I think our club was not the first of the name, but was preceded by an earlier one, the only member of which I knew was Mr. Monson Hills, the cupper. Then I should say that it is incorrect to say that Blatherwick's father was the last member, for at its disruption there were at least five members left, but one, living in Cornwall, seldom came, being very old, and another had gone to Australia, but it was agreed that we should meet no more as a club. It is quite incorrect, therefore, though unimportant, to say that I and Dr. Blatherwick dined together alone. The last time I met this very popular member of the club was at luncheon at my own house, which I well remember, because he would not allow my stepdaughter to assist him, as he had only one arm. The oldest member of the club was C. A. Aikin, a general practitioner at Bayswater, and well known at Hampstead, as so many of that distinguished family lived in this neighbourhood. After a slight paralytic attack he ceased to practise, but remained in the house, where I often visited him; he then went to live with a relative in Cumberland, where he died last year, about 90 years of age. He had a sister living close by me, who died two years ago at the age of 88. Their aunt was a most distinguished literary woman, best known as Miss Lucy Aikin, who wrote history and critiques of works of art. She lived in Church Row, Hampstead, and we are proud of having her portrait, given to us by the doctor's son, Dr. Wm. A. Aikin, of Bedford Gardens, Kensington, also a Guy's man.—Yours faithfully,

Hampstead, SAMUEL WILKS.
December 18th, 1910.

Painless Fractures.

SIR,—The following type of case is, I think, sufficiently rare to be noticed:—

G. B., 50 years of age, a Naval pensioner residing in a coast village, sent for me on the morning of Friday, December 16th, 1910 (when a terrific gale was raging over England). The messenger simply stated that the man had hurt his ankle, and bolted, in a way messengers do. So I took my First Aid, and on arrival found the man with swelling and bruising above the outer right ankle, together with a smaller bruise on the inner malleolus; loss of fibula spring. Evident fracture of the fibula, in fact, with probably tearing of the top of internal malleolus or the ligament. But there was no displacement. The accident had been caused as follows:—

During bad weather the men villagers go on to the beach to gather wreckage. This man was struck by a piece of timber across the ankle, which knocked him over, and he was rescued by his companions. He then walked about one hundred yards, dragging his foot along the ground, because of weakness only. He was then assisted home between two men. Whilst having first aid splints applied, he held his leg up in the air off the bed. He was removed to the hospital, where, so far, he is making quite uninteresting progress. The important point is that on examining him in hospital I found he had Argyll Robertson pupils and absent knee-jerk on left side (right not examined).

This interested me, as, when a dresser to Mr. Lucas, during, I think, Mr. Turner's House-Surgeonship, we admitted a man into accident (is it Astley Cooper now?) who had a transverse fracture of his tibia and fibula, and who had walked up to the hospital with the aid of a stick. He also had the Argyll Robertson pupil. We had a search through the case books afterwards, and I think only found two cases reported of painless fractures.—I am, Sir, yours faithfully,

CHARLES EDWARDS.

From the Gazette's Special Pathologist.

NOTICES.

ALL specimens—particularly those of solid tissues—should be accompanied, if possible, by a short clinical and post-mortem history, and a postal order for 2s. 6d. An extra charge of 6d. per slide is made when prepared sections are to be forwarded.

Directions to be followed in sending *Diphtheritic Membrane*;—Remove as much of the membraneous exudation as possible with a pair of forceps, which have been sterilized by boiling water. Place the exudation in a small, perfectly clean empty bottle, with a well-fitting glass stopper, and forward without delay. No preservative fluid should be used. The specimen must be accompanied by a Postal Order for 5s. A telegram will be despatched immediately the examination of the specimen is completed.

Diphtheria specimens are to be labelled *Immediate*.

Specimens, Letters, and Postal Orders should be addressed to the MANAGER, Gazette Office, Guy's Hospital.

C.E.M.J., ALTON.—This serum does not show the reaction characteristic of typhoid fever.

PATHOLOGIST.

Appointments.

Medical School Appointments.

The following appointments have been made by the Treasurer upon the recommendation of the Medical Council:—

JANUARY—MARCH, 1911.

Clinical Assistants.—Messrs. E. Billing, M. R. Dobson, J. A. Edmond, W. E. Fox, A. S. Roe, R. Stout.

Throat Dressers.—Messrs. W. P. Vicary, G. R. Hind, G. T. Mullally, F. Cook, A. C. Jepson, A. Seabrooke.

Medical Ward Clerks.—Extensions.—Messrs. A. L. Shearwood, W. K. Fry, T. I. Bennett, R. D. Passey, W. Matthews (Dr. Hale White); G. W. King, K. B. Clarke, W. C. Whitworth, E. C. Cline (Dr. Pitt); L. P. Harris, L. B. Stringer, O. R. L. Wilson, H. J. Hoby, S. Wickenden (Sir C. Perry); A. Tilbury, M. Scott, J. L. D. Lewis, H. Webb (Dr. Shaw). J. A. Ryle, C. Sherris, F. Collar, A. M. Zamora, A. C. Clifford, R. A. Fawcus, N. Garrard, F. A. Hampton, D. W. John, E. G. Martin, J. A. Martin, O. G. Morgan, W. H. Ogilvie, R. C. Ozanne, D. V. Pickering, W. R. Reynell, A. Wills.

Assistant Surgeons' Dressers.—Messrs. G. A. Pratt, C. H. G. Pochin, G. S. Miller, H. Sharpe, A. G. H. Moore, S. Keith (Mr. Steward); J. F. G. Richards, D. W. Jones, A. S. Erulkar, R. Creasy, T. A. Townsend (Mr. Fagge); H. C. Rook, G. Genge-Andrews, W. Robinson, A. S. Danby, J. L. Perceval, W. C. D. Maile (Mr. Rowlands); E. M. Mahon, F. B. Bull, V. Atienza, G. D. Eccles, K. J. T. Keer (Mr. Turner).

Surgical Ward Clerks.—Messrs. R. H. Lucas, C. H. G. Penny, E. S. Taylor.

Post-mortem Clerks.—Messrs. W. R. Reynell, R. C. Ozanne, H. L. James, W. H. Ogilvie, F. A. Hampton, R. A. Fawcus (January 1st); E. C. Peers, C. Aldis, T. P. Cole, D. A. Davies, G. T. Foster-Smith, B. R. Parmiter (February 16th).

Clerks in the Skin Department.—Messrs. N. S. Carruthers, O. R. L. Wilson.

Clerks in the Electrical Department.—Messrs. C. Aldis, C. A. R. Gatley, C. E. Reckitt.

Aural Surgeon's Dressers.—Messrs. H. G. Crawford, O. E. Williams, R. Heaton, J. M. Jarvie.

Obstetric Dressers.—Messrs. J. Pryce-Davies, G. Covell, V. Glendining, H. L. Hopkins (Mr. Targett); P. Smith, E. G. Schlesinger, T. S. Allen, A. Sandison, J. L. M. Symns (Mr. G. B. Smith).

Clinical Assistant in Medical Out-Patients.—Mr. A. J. Fradersdorff (Drs. Fawcett and French).

Assistant Physicians' Clerks.—Messrs. J. Lauder, J. M. Menagé (Drs. Beddard and Hertz).

Reviews, etc.

Books for review should be addressed to The Editor, Gazette Office, Guy's Hospital, S.E. Their price should in every case be stated.

A Text-Book of Medicine. By G. Dieulafoy, Professor of Clinical Medicine at the Faculté de Médecine de Paris; Physician to the Hôtel Dieu; Membre de l'Académie de Médecine. Authorised English Translation from the Fifteenth Edition of "Manuel de Pathologie Interne" by V. E. Collins, M.D. Lond., M.R.C.S., L.R.C.P., and J. A. Liebmann. Ph.D., M.A., LL.D., (in two volumes, pp. 2081). (Ballière, Tindall & Cox, London.)

An English translation of Professor Dieulafoy's well-known text-book, which has reached its fifteenth edition, will no doubt appeal strongly to many post-graduates whose knowledge of French is weak. The authors are to be congratulated upon the result of their labours, which must have been immense. We have had abundant proof in our review of the care which they have taken to ensure that the book should lose nothing of accuracy or of graphic description by their translation. Their work has been thorough, and it is characterised by an exhaustive attention to detail in production.

We have no doubt of the great value of the book to those engaged in post-graduate work, but we wish to say most emphatically that it is *not* a book which will be of any service to those students who are reading for a qualification in Medicine. The reasons for this statement are as follows:—

Firstly, the work has been founded upon a series of clinical lectures on various interesting subjects, illustrated by accounts of cases which have been found by Professor Dieulafoy either in hospital or private work. Very careful and complete clinical notes of these patients are given, but they will often be misleading to the student with a limited knowledge of medicine, however interesting they may be to the post-graduate.

Secondly, there is always a tendency, when a text-book is built up upon a series of clinical lectures, that the writer may enlarge upon those subjects which have specially interested him, dismissing in short paragraphs and with poor description other subjects of less interest, but which he is obliged to introduce in order to make the book complete. Professor Dieulafoy has made this mistake. *He does not indicate the relative importance of the various affections he describes.* For example, he devotes fifteen pages to the subject of hydatid disease of the liver, while a poor account of angina pectoris occupies only five pages. Many complete clinical reports are given of the former, and none are given to illustrate the latter. Again, some twenty pages are devoted to a descrip-

tion of syphilitic disease of the lung, while the subject of pneumothorax is dismissed in four pages, and only five pages are allowed for duodenal ulcer. Both the two latter articles are very poor. We mention these points merely to indicate that the work can by no stretch of imagination be described as a text-book for students.

Thirdly, morbid anatomical descriptions are often very poor. Especially is this the case in connection with pneumatic consolidation, diphtheritic membranous formation, and lardaceous change. A short account of acute intestinal obstruction gives no indication of the relative frequency with which the various conditions described are responsible for trouble.

Our fourth objection to the book is that the author takes little or no notice of research or other original work in medicine which has been done either in Germany, America or in this country. In the preface to this translation Pro. Dieulafoy makes tardy acknowledgment of the enormous amount of work due to British physicians and surgeons, but this reads rather like an apology for the almost complete disregard in the text of all work outside the land of France.

Apart from these objections, the book is a splendid record of clinical work. First of all there is the article on Pleurisy, its treatment, and the indications for "tapping." Then there is the exhaustive chapter on Appendicitis, and the sections devoted to the diagnosis and treatment of this disorder are probably the best in the book. Atrophic Cirrhosis of the Liver forms the subject of another good article, although we are bound to say that the description of the microscopical changes will leave the student in doubt as to what is the author's real conception of "cirrhosis" as a pathological change. Thus, in the second paragraph on page 879 we are told that there is no change in the hepatic cells. The hepatitis is described as interstitial and not as parenchymatous, whereas in the ninth paragraph on the same page, compensatory hyperplasia of the hepatic cells and "adenomatous" changes are both mentioned as characteristic of "cirrhosis." This is another example of the carelessness with which the descriptions of morbid anatomy have been written. The descriptions of heart disease, valvular trouble and its treatment are, perhaps, the most disappointing in the book. A good deal more space could have been devoted with advantage to these sections.

We read on page 733 that appendicitis has only been recognised since the year 1888. This may be the case in France, but before the sixteenth edition of the book appears the author would do well to inspect the post-mortem records at Guy's, where the disorder was described many years previous to that date.

Most extraordinary also is it to find that in a book published in 1910 only twelve lines are devoted to the treatment of duodenal ulcer, and the one and only reference to surgical work in connection with this complaint is fifteen years old (1895). As we have said above, the section devoted to duodenal ulcer only occupies four pages.

The second volume of the work is devoted to "Nervous Diseases," of which there is a very complete account, with much clinical material. The sections dealing with the specific fevers are also well arranged. The articles on renal disease are perhaps confusing, because the author does not restrict the term "Bright's disease" to that particular form of renal trouble described by Dr. Bright, using the words in a much wider sense. We do not quite understand why "Diabetes" should form a sub-heading in a chapter which is devoted to "Rheumatism," especially as it is stated that "acute rheumatism has all the attributes of an acute infective disease." The association of chorea with acute rheumatism is not considered to be so close as is the case in this country, and no mention is made of the bacteriological research work which has been carried out by Drs. Poynton and Paine. We thought that the article in Volume I. upon "Inflammation of the Chest" (p. 120) was reminiscent of an old-world pathology, and though the cases quoted are very interesting, a much simpler explanation is possible in the light of modern clinical medicine.

Sport.

Rugby Football.

GUY'S v. NORTHAMPTON.

Played at Northampton on Saturday, December 3rd, and in wet weather, the Hospital went down by 16 points to nil (2 goals and 2 tries). Guy's went to Northampton with a side weakened by injured absentees, and, further, Hind was not by any means well, although he turned out; he was really more fit for bed than for a hard game of Rugby. His example to do his very utmost for the Hospital may be noted by other Rugby men who feel disposed to scratch without any real reason, and who apparently forget that to play for any XV. of Guy's men is an honour to be proud of and appreciated.

Guy's had to defend for almost all the first half, and after conceding a minor a penalty was given against them. Coles took the kick, and just missed the goal; it was an awkward place, and splendidly taken. Within a few minutes passing and interpassing by Beasley and Cook enabled the latter to score; Coles could not convert. Again Cook added a try, and this time Coles added the extra points. Lacey stopped a great rush, and half-time was taken.

The forwards were now going better, but there were practically only seven of them, although the "skipper" pluckily did his best. The Northampton backs were pressed, but no score resulted, although on one occasion Lacey ran through the opposition to be tackled on the line. Then before the end Mobbs added a try, which

Coles converted, and Williamson also put on an unconverted try. Before the end Mobbs hurt his wrist and thumb and had to retire, so that Northampton finished with 14 men. Guy's finished strongly, but though their efforts to reduce the lead were well sustained nothing came off for them, and the game ended as stated above. Team :—

GUY'S.—G. E. W. Lacey (back); L. B. Stringer, E. Nicholls, G. C. Covell, H. W. Evans (three-quarters); J. E. Davies, C. H. Medlock (halves); G. R. Hind, C. S. L. Roberts, W. S. Stranack, R. S. Kennedy, T. D. Stout, O. G. Parry-Jones, L. Horsley, A. W. A. Davies (forwards).

REMARKS. — Under the existing circumstances the team did exceedingly well. The team was not Guy's strongest, but it was composed of willing sportsmen who did their very best, and no man can do more. With the Cup ties approaching it is much to be hoped that a regular team will be available, made up of players who can be relied on to put aside for the time being private considerations and do their utmost to uphold the prestige of their Hospital, and to make sure, at all costs, that the Cup does not leave, even for a year, our custody.

It is very gratifying to know that the sterling qualities of the Guy's Rugby Captain, Mr. G. R. Hind, have again been recognised by the Rugby selectors whose duty it is to build up the International team. Mr. Hind was chosen to represent England against the South and also against the North. Mr. Stranack, also, fairly earned a place in the South side, and many thought his display at Twickenham against the English side merited promotion. If England has eight better forwards than Mr. Stranack, then indeed her pack should be superlative. Messrs. Stringer, Roberts, and Saner were also at Twickenham on December 10th, acting as reserves.

GUY'S v. RICHMOND.

As stated elsewhere, Guy's resources were somewhat drained on Saturday, December 10th, by so many players being called upon to attend at Twickenham. One or two others at the last moment found it impossible to go to Richmond, so that eventually Guy's turned out with only 13 men, and, with the exception of three or four, all members of the Second XV.

But Richmond were beaten—with seven men in the pack, and Medlock by himself as a scrum and stand-off half rolled into one. The back division, with Stokes reappearing, gave an excellent showing. But the pack paved the way for the win. They started "running" to begin with, and kept it up right to the end by hard determined forward play. There was not too much picking up, and every man did his best, and there was no waiting about to get "on-side." Bowes was the first to score. He intercepted a pass when Richmond were pressing, and got right away to touch for a try in a good position; but Stokes failed to goal. Greatly encouraged, Guy's went well for a time. But Richmond equalised; Watson, Terry, and Ireland combining well, the last named gained an unconverted try. Just before half-time the forwards swept over the line, Danby touching down, and Stokes converting. Guy's crossed over with a lead of 8 points to 3.

Early in the second half Richmond's full-back was injured and compelled to retire. They made great efforts to get on terms, but the Hospital men always appeared to have the game in hand. Stokes added a try after gathering very neatly, but the place kick, taken by himself, was unsuccessful. Goodman, with Watson and Ireland, was often dangerous, but Guy's hung on to their advantage; they tackled finely, Lacey doing splendid work. Before the end Medlock gained 3 points. His try was the result of good individual work, and as this was all the scoring, the end came with Guy's leading by 1 goal, 3 tries to 1 try, or 14 points to 3. Team :—

GUY'S.—G. E. W. Lacey (back); A. L. Stokes, G. C. Covell, W. Gwyn Davies, B. S. Bowes (three-quarters); C. H. Medlock (half); A. W. A. Davies, T. D. M. Stout, L. Horsley, R. Stout, R. Liebson, C. Gibb, A. R. Danby (forwards).

REMARKS.—No criticism of the game is necessary. It was a thoroughly deserved win, reflecting great credit on all who took part in it.

NOTICES.

Guy's Hospital Students' Club.

The following books, containing no names, or names unknown to me, have been found in the Club Reading Room :—

Essays	John Bright.
First Principles ...	Herbert Spencer.
Spoils of Victory ...	H. O. Brookhouse.
Modern Europe ...	A. Phillips.
Advanced Heat ...	R. W. Stewart.
Small Lathes ...	Jas. Luhn.
Metal Turning ...	Marshall.

The owners should apply to me in writing for them. Any not claimed by January 14th will be sold.

T. B. LAYTON, Hon. Sec.

Guy's Hospital,
Dec. 16th, 1910.

Marriage.

DOUBLEDAY—BARROW-CLOUGH.—On December 21st, at the Wimbledon Wesleyan Church, by the father of the bride, assisted by the Revs. J. Telford, B.A., and H. Bramley Hart, Frederic Nicklin Doubleday, L.D.S. Eng., of 4, St. Thomas's Street, S.E., to Esther Jane, daughter of the Rev. J. A. Barrow-Clough, B.A., B.D.

Birth.

MAY.—On December 19th, at the White House, Sonning-on-Thames, to Dr. and Mrs. Norman May, a daughter.

ED.—A. N. C.

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